UNUSUAL CASES

In unusual cases requiring extended daily visits, or in cases with unusual complications, a special report should accompany statement in order that regular fee may be adjusted on an equitable basis.

(Fees are enumerated under the headings listed on the first page.)

Plaintiff's Exhibit 198

3968 Oregon State Medical Society

COMMITTEE ON CONTRACT PRACTICE—1937

E. D. Lamb, Klamath Falls
Chairman
Thompson Corberth, The Dalles
(deceased)
O. C. Hagmeier, Astoria
Richard B. Adams, Portland
(deceased)
Dean P. Crowell,
North Bend
W. W. Baum, Salem
George E. Henton,
Portland
J. C. Hayes,
Medford

COMMITTEE ON MEDICAL ECONOMICS—1938

Thompson Coberth, The Dalles
(deceased) Chairman
E. D. Lamb, Klamath Falls
O. C. Hagmeier, Astoria
Richard B. Adams, Portland
(deceased)
Dean P. Crowell,
North Bend
W. W. Baum, Salem
George E. Henton,
Portland
J. C. Hayes,
Medford

COMMITTEE ON THE PROVISION OF MEDICAL CARE TO EMPLOYEE GROUPS IN DISTRICTS NOT NOW SERVED BY ANY APPROVED MEDICAL SERVICE BUREAU—1941

George E. Henton, Portland
Chairman
F. K. Power, Salem
Thompson Coberth, The Dalles
(deceased)
C. J. Bartlett, Baker
E. R. Durno,
Medford
L. M. Spalding,
Astoria
Dean P. Crowell,
Marshfield

Plaintiff's Exhibit 199

3969

MULTNOMAH COUNTY MEDICAL SOCIETY

COMMITTEE ON PUBLICITY

1936

Richard B. Adams (deceased), Chairman
A. G. Bettman, Medical Arts Building
W. F. Hollenbeck, 919 Taylor Street Building
Leo J. Meienberg, Mayer Building
Charles O. Sturdevant, 1033 Gayle Avenue, Los Angeles, California

1937

Richard B. Adams (deceased), Chairman
Morris L. Bridgeman, 4212 N.E. Broadway
Banner R. Brooke, 610 N.E. 39th Avenue
Karl H. Martzloff, Medical-Dental Building
John R. Hand, 1216 S.W. Yamhill Street

1938

Richard B. Adams (deceased), Chairman
W. F. Hollenbeck, 919 Taylor Street Building
W. K. Livingston, 3181 S.W. Marquam Hill Road

1939

Robert L. Thomas, 400 29th Street, Oakland, California, Chairman
Thomas W. Ross (deceased)
Edwin P. Fagan (deceased)

Committee of Public Relations

1940

Blair Holcomb, 2222 N.W. Lovejoy Street, Chairman
Frank R. Mount (deceased)
Robert L. Benson, Medical-Dental Building

1941

Frank R. Mount (deceased), Chairman
Robert L. Benson, Medical-Dental Building
Charles E. Gurney, Medical Arts Building

3970

1942

T. Homer Coffen, Standard Insurance Building, Chairman
Andrew C. Smith (deceased)
A. M. Webster, 125 N.W. 20th Place

1943

Birchard A. Van Loan, Standard Insurance Building, Chairman
Ivan M. Woolley, Medical Arts Building
William A. Shea, Corbett Building

1944

Birchard A. Van Loan, Standard Insurance Building, Chairman
Gordon B. Leitch, Medical Arts Building
William A. Shea, Corbett Building

1945

S. G. Henricke, 3700 N.E. Sandy Boulevard, Chairman
Forrest E. Rieke, 210-A N.E. Oregon Street, Vice-Chairman
Martin F. Gilmore, Standard Insurance Building
Gordon B. Leitch, Medical Arts Building
Homer P. Rush, 919 Taylor Street Building

1946

Forrest E. Rieke, 210-A N.E. Oregon Street, Chairman
Donald E. Forster, Medical-Dental Building
S. G. Henricke, 3700 N.E. Sandy Boulevard
Gordon B. Leitch, Medical Arts Building
Raymond W. Mangels, 4212 N.E. Broadway
Gordon B. Prewitt, 1216 S.W. Yamhill Street

1947

Forrest E. Rieke, 210-A N.E. Oregon Street, Chairman
Gordon B. Leitch, Medical Arts Building
Ralph A. Fenton, Medical Arts Building
Clifford W. Kuhn, Medical Arts Building
Frank Perlman, Medical-Dental Building
Blair Holcomb, 2222 N.W. Lovejoy Street
J. F. Paquet, 2455 N.W. Marshall Street

1948

Forrest E. Rieke, 210-A N.E. Oregon Street, Chairman
Gordon B. Leitch, Medical Arts Building, Vice-Chairman
John A. Gius, Medical-Dental Building
Blair Holcomb, 2222 N. W. Lovejoy Street
J. F. Paquet, 2455 N.W. Marshall Street

Plaintiff's Exhibit 200

3971

MULTNOMAH COUNTY
MEDICAL SOCIETY

SPECIAL COMMITTEES

COMMITTEE ON THE STUDY OF NEW PLANS OF MEDICAL CARE—1937

S. G. Henricke, 3700 N.E. Sandy Boulevard, Chairman
Blair Holcomb, 2222 N.W. Lovejoy Street
E. E. Gambee, Medical-Dental Building
Charles O. Sturdevant, 1033 Gayle Avenue, Los Angeles, California
C. E. Brous (deceased)

COMMITTEE ON THE STUDY OF PLAN OF MEDICAL CARE FOR LOW-WAGE INDUSTRIAL GROUPS—1938

Stanley Lamb, Medical Arts Building, Chairman
B. O. Woods, 919 Taylor Street Building
Charles E. Sears, Medical Arts Building

COMMITTEE ON THE STUDY OF PLANS OF MEDICAL CARE FOR LOW-WAGE INDUSTRIAL GROUPS—1939

Stanley Lamb, Medical Arts Building, Chairman
B. O. Woods, 919 Taylor Street Building
Charles E. Sears, Medical Arts Building
W. H. Bueermann, 919 Taylor Street Building
George E. Henton, Standard Insurance Building
Harry B. Moore, Medical-Dental Building
Frank R. Mount (deceased)

COMMITTEE ON PLANS OF MEDICAL CARE FOR LOW-WAGE INDUSTRIAL GROUPS—1939

Roy A. Payne (deceased), Chairman
Noble Wiley Jones, Saratoga Inn, Saratoga, California
Dean B. Seabrook, Mayer Building

COMMITTEE ON PLANS OF MEDICAL CARE FOR LOW-WAGE INDUSTRIAL GROUPS—1940

Stanley Lamb, Medical Arts Building, Chairman
Ralph V. Moore (deceased)
Thomas D. Robertson (deceased)

COMMITTEE ON PLANS OF MEDICAL CARE FOR LOW-WAGE INDUSTRIAL GROUPS—1941

Charles P. Wilson, 2455 N.W. Marshall Street, Chairman
Thomas D. Robertson (deceased)
Earl M. Anderson, 3236 N. E. Ainsworth Street

COMMITTEE ON PLANS OF MEDICAL CARE FOR LOW-WAGE INDUSTRIAL GROUPS—1942

Richard B. Adams (deceased), Chairman
Earl M. Anderson, 3236 N.E. Ainsworth Street
Thomas D. Robertson (deceased)

3972 COMMITTEE ON PLANS OF MEDICAL CARE FOR LOW-WAGE INDUSTRIAL GROUP—1943

Richard B. Adams (deceased), Chairman

Vernon J. Brown, 2925 Eucalyptus Avenue, Long Beach, California
Harold L. Blosser (deceased)

Plaintiff's Exhibit 201

3973 MULTNOMAH COUNTY MEDICAL SOCIETY

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

1936

Thomas Wynne Watts (deceased), Chairman
Ralph A. Fenton, Medical Arts Building
A. M. Webster, 125 N.W. 20th Place
Banner R. Brooke, 610 N.E. 39th Avenue
John C. Adams, Medical-Dental Building
W. J. Gilstrap, 405 N. Russett Street

1937

Banner R. Brooke, 610 N.E. 39th Avenue, Chairman
Richard B. Adams (deceased)
F. Floyd South, Mayer Building

1938

Charles E. Sears, Medical Arts Building, Chairman
George E. Henton, Standard Insurance Building
Merl L. Margason, 1216 S.W. Yamhill Street

1939

Richard B. Adams (deceased), Chairman
George E. Henton, Standard Insurance Building
John R. Montague, Medical Arts Building

COMMITTEE ON PUBLIC POLICY

1940

Richard B. Adams (deceased), Chairman
George E. Henton, Medical Arts Building
Charles C. Newcastle, Mayer Building

1941

Richard B. Adams (deceased), Chairman
George E. Henton, Standard Insurance Building
Charles C. Newcastle, Mayer Building

1942

Richard B. Adams (deceased), Chairman
George E. Henton, Standard Insurance Building
Charles C. Newcastle, Mayer Building

1943

Richard B. Adams (deceased), Chairman
Karl H. Martzloff, Medical-Dental Building
Stanley Lamb, Medical Arts Building

1944

Richard B. Adams (deceased), Chairman
Karl H. Martzloff, Medical-Dental Building
Stanley Lamb, Medical Arts Building

1945

Karl H. Martzloff, Medical-Dental Building, Chairman
Richard B. Adams (deceased)
Robert S. Dow, Medical-Dental Building
Stanley Lamb, Medical Arts Building
J. Milton Murphy, Morgan Building

1946

J. Milton Murphy, Morgan Building, Chairman
Allen M. Boyden, 1216 S.W. Yamhill Street
E. Murray Burns, 2222 N.W. Lovejoy Street
Robert S. Dow, Medical-Dental Building
Karl H. Martzloff, Medical-Dental Building

1947

J. Milton Murphy, Morgan Building, Chairman
Matthew McKirdie, 2455 N.W. Marshall Street
Robert F. Miller, Standard Insurance Building
Joyle Dahl, Medical Arts Building
Gordon B. Leitch, Medical Arts Building

1948

Franz R. Stenzel, 2455 N.W. Marshall Street, Chairman
Robert M. Coffey, 2138 S.W. Salmon Street
James B. Foley, 5825 N. Greeley Avenue

Plaintiff's Exhibit 202

3975 MULTNOMAH COUNTY
MEDICAL SOCIETY

GRIEVANCE COMMITTEE

1936

Karl H. Martzloff, Medical-Dental Building, Chairman
Richard B. Adams (deceased)
Frederick A. Kiehle, Medical Arts Building

1937

Richard B. Adams (deceased), Chairman
Frederick A. Kiehle, Medical Arts Building
(served from January 6th to May 4th—then resigned)
Willard F. Hollenbeck, 919 Taylor Street Building
(elected May 4th—served balance of year)
Stanley Lamb, Medical Arts Building

1938

Stanley Lamb, Medical Arts Building, Chairman
E. E. Gambee, Medical-Dental Building
Roger Holcomb, Medical Arts Building

1939

Stanley Lamb, Medical Arts Building, Chairman
Roger Holcomb, Medical Arts Building
Dean B. Seabrook, Mayer Building

1940

Stanley Lamb, Medical Arts Building, Chairman
B. O. Woods, 919 Taylor Street Building
Roger Holcomb, Medical Arts Building

1941

Stanley Lamb, Medical Arts Building, Chairman
John Besson, 1024 S.W. 6th Avenue
Roger H. Keane, Mayer Building

1942

Stanley Lamb, Medical Arts Building, Chairman
Roger H. Keane, Mayer Building
Paul Bailey, Medical-Dental Building

3976

1943

Thomas D. Robertson (deceased), Chairman
Stanley Lamb, Medical Arts Building
Martin A. Howard, Medical Arts Building

1944

Thomas D. Robertson (deceased), Chairman
Stanley Lamb, Medical Arts Building
Martin A. Howard, Medical Arts Building

1945

Stanley Lamb, Medical Arts Building, Chairman
William H. Thayer, 1618 S.E. Bybee Avenue
Birchard A. Van Loan, Standard Insurance Building

1946

No record of appointment.

1947

Robert L. Benson, Medical-Dental Building, Chairman
(served from January 7th to February 4th—then resigned)
T. Homer Coffen, Standard Insurance Building
(elected February 4th—served balance of year)
E. E. Gambee, Medical-Dental Building
Howard P. Lewis, 3181 S.W. Marquam Hill Road

1948

John C. Adams, Medical-Dental Building, Chairman
E. E. Gambee, Medical-Dental Building
Wilmot C. Foster, 919 Taylor Street Building

Plaintiff's Exhibit 203

3977

MULTNOMAH COUNTY
MEDICAL SOCIETY
BOARD OF CENSORS

1936

Charles E. Sears, Medical Arts Building, Chairman
Robert L. Benson, Medical-Dental Building
Frank R. Mount (deceased)

1937

Charles E. Sears, Medical Arts Building, Chairman
Robert L. Benson, Medical-Dental Building
(served from January 6th to February 8th—then resigned)
Roy A. Payne (elected March 2nd—served balance of year) (deceased)
Frank R. Mount (deceased)

1938

Charles E. Sears, Medical Arts Building, Chairman
Roy A. Payne (deceased)
Karl H. Martzloff, Medical-Dental Building

1939

Charles E. Sears, Medical Arts Building, Chairman
Roy A. Payne (deceased)
E. E. Gambee, Medical-Dental Building

1940

Charles E. Sears, Medical Arts Building, Chairman
E. E. Gambee, Medical-Dental Building
Ernest L. Boylen, Standard Insurance Building

1941

Charles E. Sears, Medical Arts Building, Chairman
E. E. Gambee, Medical-Dental Building
Ralph V. Moore (deceased)

1942

Charles E. Sears, Medical Arts Building, Chairman
Ralph V. Moore (deceased)
Charles C. Newcastle, Mayer Building

3978

1943

Charles E. Sears, Medical Arts Building, Chairman
Charles C. Newcastle, Mayer Building
H. L. Blosser (deceased)

1944

H. L. Blosser, (deceased), Chairman
(served from January 4th to his death on November 4th)
Charles E. Sears, Medical Arts Building
(elected December 5th—served balance of year)
Harry S. Irvine, Selling Building
Charles P. Wilson, 2455 N.W. Marshall Street

1945

Charles E. Sears, Medical Arts Building, Chairman
Harry S. Irvine, Selling Building
Charles P. Wilson, 2455 N.W. Marshall Street

1946

Matthew C. Riddle, Medical Arts Building, Chairman
Harry S. Irvine, Selling Building
Merl L. Margason, Mayer Building

1947

Matthew C. Riddle, Medical Arts Building, Chairman
Harry S. Irvine, Selling Building
Dean B. Seabrook, Mayer Building

1948

E. G. Chuinard, Medical-Dental Building, Chairman
Wilbur M. Bolton, Medical Arts Building
Leo J. Meienberg, Mayer Building

Plaintiff's Exhibit 204

3979

MULTNOMAH COUNTY
MEDICAL SOCIETY

COMMITTEE ON MEDICAL ECONOMICS

1936

Stanley Lamb, Medical Arts Building, Chairman
C. L. Rybke (deceased)
John R. Montague, Medical Arts Building
Roy A. Payne (deceased)
Louis P. Gambee, Medical-Dental Building
R. A. Bissett, Tigard
Eugene P. Owen, 919 Taylor Street Building
Leon A. Goldsmith, Medical-Dental Building

1937

Blair Holcomb, 2222 N.W. Lovejoy Street, Chairman
James E. Buckley, Medical-Dental Building
George E. Henton, Standard Insurance Building
Charles O. Sturdevant, 1033 Gayle Avenue, Los Angeles, California
E. E. Gambee, Medical-Dental Building

1938

Blair Holcomb, 2222 N.W. Lovejoy Street, Chairman
S. G. Henricke, 3700 N.E. Sandy Boulevard
James E. Buckley, Medical-Dental Building
George E. Henton, Standard Insurance Building
Charles O. Sturdevant, 1033 Gayle Avenue, Los Angeles, California
E. E. Gambee, Medical-Dental Building

1939

No record of appointment

1940

George E. Henton, Standard Insurance Building, Chairman
Guy L. Boyden, 1735 N. Wheeler Avenue
Harold L. Blosser (deceased)

1941

Harold L. Blosser (deceased), Chairman
Guy L. Boyden, 1735 N. Wheeler Avenue
James E. Buckley, Medical-Dental Building

3980

1942

Noble Wiley Jones, Saratoga Inn, Saratoga, California, Chairman
Harold L. Blosser (deceased)
S. H. Sheldon (deceased)

1943

Noble Wiley Jones, Saratoga Inn, Saratoga, California, Chairman
Harold L. Blosser (deceased)
Leon A. Goldsmith, Medical-Dental Building

1944

Noble Wiley Jones, Saratoga Inn, Saratoga, California, Chairman
J. Otto George, 919 Taylor Street Building
Leon A. Goldsmith, Medical-Dental Building

1945

Leon A. Goldsmith, Medical-Dental Building, Chairman
Rudolph M. Crommelin, Mayer Building
Gordon B. Prewitt, Boston, Massachusetts

1946

Leon A. Goldsmith, Medical-Dental Building, Chairman
Rudolph M. Crommelin, Mayer Building
Gordon B. Prewitt, Boston, Massachusetts

1947

James E. Buckley, Medical-Dental Building, Chairman
Frank Perlman, Medical-Dental Building
John P. Trommald, 2455 N.W. Marshall Street

1948

James E. Buckley, Medical-Dental Building, Chairman
W. H. Bueermann, 919 Taylor Street Building
John P. Trommald, 2455 N.W. Marshall Street

Plaintiff's Exhibit 205

3981

MULTNOMAH COUNTY MEDICAL SOCIETY

COMMITTEE ON HOSPITAL BETTERMENT

1936

Thomas M. Joyce, (deceased), Chairman
Eugene W. Rockey, Medical Arts Building
Raymond M. Watkins, (deceased)
W. B. Holden, Medical Arts Building
Roy A. Payne, (deceased)
John H. Fitzgibbon, Standard Insurance Building

1937

Eugene W. Rockey, Medical Arts Building, Chairman
Thomas M. Joyce, (deceased)
Eugene P. Steinmetz, Medical Arts Building
Luther T. Nelson, Medical Arts Building

1938

Earl D. DuBois, Medical Arts Building, Chairman
Merl L. Margason, 1216 S.W. Yamhill
A. M. Webster, 125 N.W. 20th Place
Luther T. Nelson, Medical Arts Building

1939

Earl D. DuBois, Medical Arts Building, Chairman
William M. Wilson, Medical Arts Building
Charles H. Smith, 3418 S.E. Belmont Street
William A. Shea, Corbett Building

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

1940

William A. Shea, Corbett Building, Chairman
V. E. Dudman, (deceased).
E. E. Rippey, Medical Arts Building

1941

William A. Shea, Corbett Building, Chairman
C. O. Sturdevant, 1033 Gayley Street, Los Angeles
E. E. Rippey, Medical Arts Building

3982 1942

Blair Holcomb, 2222 N.W. Lovejoy, Chairman
William A. Shea, Corbett Building
C. W. Brunkow, Medical Arts Building
Arthur D. Pochert, 306 S.E. 80th Avenue
Donald R. Laird, 919 Taylor Street Building
John H. Besson, 1024 S.W. 6th Avenue

1943

S. G. Henricke, 3700 N.E. Sandy Boulevard, Chairman
Blair Holcomb, 2222 N.W. Lovejoy
Thomas M. Joyce, (deceased)
C. Harold Palmer, Peninsula Bank Building
John H. Besson, 1024 S.W. 6th Avenue
Louis P. Gambee, Medical-Dental Building
Charles N. Holman, 3181 S.W. Marquam Hill Road

1944

Collie, P. Cathey, Morgan Building, Chairman
John H. Besson, 1024 S.W. 6th Avenue
Louis P. Gambee, Medical-Dental Building
Charles N. Holman, 3181 S.W. Marquam Hill Road
H. H. Hughes, Gresham, Oregon
Thomas M. Joyce, (deceased)
Leo S. Lucas, Medical-Dental Building
William A. Shea, Corbett Building

1945

Merl L. Margason, 1216 S.W. Yamhill, Chairman
George K. Armen, Medical-Dental Building
Charles N. Holman, 3181 S.W. Marquam Hill Road
H. H. Hughes, Gresham, Oregon
Karl H. Martzloff, Medical-Dental Building
Oliver M. Nisbet, Medical-Dental Building
William A. Shea, Corbett Building
Ivan M. Woolley, Medical Arts Building

1946

No record of appointment

1947

No record of appointment

Lee W. Dickinson, Selling Building, Chairman
Theodore W. Adams, Medical Arts Building
I. C. Brill, Medical Arts Building
Charles N. Holman, 3181 S.W. Marquam Hill Road
Warren C. Hunter, 3181 S.W. Marquam Hill Road
Leo J. Meienberg, Mayer Building
Walter H. Munroe, 919 Taylor Street Building
Dean B. Seabrook, Mayer Building
Paul E. Shininger, 5402 S.E. Foster Road

Plaintiff's Exhibit 206

3984

MULTNOMAH
INDUSTRIAL HEALTH ASSOCIATION

Business Office 935 S.W. Yamhill Street

(Emblem)

'Phone BEacon 6606 Corner Tenth Avenue
Portland, Oregon

November 24, 1933

Columbia County Medical Society
Rainier, Oregon

Attention—Dr. M. A. Kenney, Secretary

Gentlemen:

In accordance with instructions of the Directors of the Multnomah Industrial Health Association, the undersigned is setting forth a plan whereby the membership of your group can join us in our efforts to eliminate the lay-owned Hospital Associations from the practice of medicine.

In Portland, our stockholders are pledged not to sell their services to lay-owned hospital associations. We realized, as a result of a free, frank discussion with your Committee, that for the present your members cannot afford to refuse lay-owned hospital association employment because of the difficult economic situation. Believing that you may be willing to enlist with us in this battle of principle, we submit to you a plan whereby you may make a beginning, in your several communities, of securing contracts for yourselves, thus eliminating laymen in the sale of your services.

First: You must have 100 percent cooperation of your fellow practitioners.

Second: You will each purchase one share of stock, costing $100.00, payable as is most agreeable to you, thus permitting you to take advantage of our qualification with the Insurance Department of the State.

Third: We will assist, with our Sales staff, in the procuring of such contracts as you shall indicate.

Fourth: The funds collected from Columbia County contracts will be set apart as a separate fund and will be distributed on the following basis. 30 percent to cover administrative costs and the remaining 70 percent for the care of Columbia County contracts. Services of hospitals, dentists, drug stores, nurses, ambulance services, first aid supplies, etc., to be first paid from the 70 percent, and the balance pro-rated among the Coumbia County doctors rendering service;—our fee schedule as a basis.

3985 Cases arising from Portland contracts, treated by Columbia County doctors who are members of this Association; will not come under this percentage basis but will be handled the same as in Multnomah County.

Copies of our forms, By-Laws, fee schedule, etc., were given to you by Mr. Voris.

Should you decide to enlist with us on the above basis, we can assure you our most hearty cooperation.

At your service,

Fraternally yours,

(Signed) F. H. DAMMASCH, M. D.

F. H. Dammasch, M. D.
Secretary-Treasurer
MULTNOMAH INDUSTRIAL
HEALTH ASSOCIATION

FHD:HK

Plaintiff's Exhibit 207

3986 MULTNOMAH MEDICAL SERVICE BUREAU

PORTLAND, OREGON April 28, 1941

Bulletin No. 35

The Board of Directors takes this opportunity of thanking the Stockholders for their prompt assent to the stock change as required by the State Insurance Department. Only six physicians have failed to comply and of these three are in the army service. Our staff now numbers *330* physicians.

The Board of Directors invites attention to the matter of continued close cooperation in view of the *increase* in hospital rates and special nurse charges and again wishes to remind the staff that:

You are paying your patient's hospital bill,

You pay for all special nurses,

You pay all drug bills,

You pay all ambulance bills,

You are paid from what is left.

You were recently assigned a code number to be used by you on all bills coming to the Bureau. The purchase of a rubber stamp with your name and code number is suggested. Example: *John Henry Medico 01-426.* It would save you time and lighten the clerical work in this office. If you desire to purchase such a stamp, please phone *Br. 0453* for information as to cost.

Unless all slips are *completed* as per instructions recently mailed to you, they will be returned to your office for completion before payment can be considered.

By resolution of the Board, the following ruling is effective April 1, 1941: Unless a *report* of X-ray findings is submitted to this office, no fee will be paid for X-rays.

A new fee schedule is in the making. Dr. Charles C. Newcastle is chairman of the committee and will welcome any suggestions from staff physicians.

Our books are now closed to all bills for services *prior* to January 1, 1941. By Board resolution, bills received after April 10, 1941 for the quarter ending March 31, 1941, are subject to 10% penalty. The dead-line for the present quarter is *July 10, 1941,* after which date the usual penalty will

be envoked. Please cooperate and save yourself a needless penalty.

Now subscribers cannot be under coverage until we receive and pass upon the physical examinations made by you. Please mail them to us *immediately* upon completion. You can readily see the importance of promptness in this matter.

MULTNOMAH MEDICAL SERVICE BUREAU

F. H. Dammasch, M. D.,
Medical Director

Important

Many of our subscribers are now working on night shifts. Please detach this paragraph, sign, and return to this office if you are willing to accept night emergency calls for Industrial injuries.

.....

I am available for night emergency calls

3987 NORTHWEST MEDICINE

THE JOURNAL OF THE STATE MEDICAL ASSOCIATIONS OF OREGON, WASHINGTON, IDAHO, AND PACIFIC NORTHWEST MEDICAL ASSOCIATION

Issued Monthly by Northwest Medical Publishing Association

Office of Publication, 543 Stimson Building, Seattle, Wash.

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Vol. 35 AUGUST, 1936 No. 8

Plaintiff's Exhibit 208

3988 EDITORIAL

THE HOSPITAL ASSOCIATION SITUATION IN PORTLAND

During recent weeks considerable newspaper publicity has been given to the action of Multnomah County Medical Society in deciding no longer to sponsor Multnomah Industrial Health Association. In order that the profession of the Northwest may have correct information concerning this procedure, the following explanation is offered which presents a correct report of the manner in which the county society has dealt with this controversy.

For many years the question of hospital associations and contract practice has disturbed the society's tranquility. With the depression the income of physicians diminished as did that of all other groups. Perhaps it was the economic problem that stimulated some doctors to note that much industrial work went to hospital associations, and that a large number of patients were being treated at free clinics. Whether in consideration of or despite these observations it would be difficult to determine, suffice it to say, that a number of the most ethical Portland doctors conceived the idea that prepayment of medical services by employees in the low income group would not only solve the medical problem of these employees, but would also assist physicians in meeting their own problems. They reasoned that, with a physician-owned association, they would have such a large panel as to give practically free choice of physicians, and that with this argument they could attract much of the work which was going to the then organized hospital associations with their very limited panels. By this method, they figured, they could care for the low income group in a manner that would preserve their self-respect. It was hoped that ultimately the commercial hospital associations, with their solicitation of patients, might be driven from the field. With these objects in mind, Multnomah Industrial Health Association was organized. The council of Multnomah County Medical Society, many of whose members had joined the association, set out certain principles with the statement that any association that abided by them would receive the indorsement of the society. The Multnomah Association received this indorsement.

In the administration of their affairs, the Multnomah Association was forced, in order to meet the competition

of the commercial associations, to advise employers and employees regarding their organization. This, of course, constituted solicitation in contravention of the code of ethics of the American Medical Association and of the principles promulgated by the council. An attempt was made to eliminate the objectionable features, but was not entirely successful. In the meantime the personnel of the council changed. The Bulletin of the American Medical Association of approximate date contained articles on solicitation of patients and was conducive of much thought and discussion. The members of the society then became divided on the questions involved and a number resigned from the Multnomah organization. However, new members were signing up. The county society, also, addressed the membership on the subject of solicitation.

The matter was definitely brought to a head when a contract was entered into by Multnomah Industrial Health Association and teachers of the public schools. It was felt by many members that this service should not be offered to this class who earned over $1500 a year, and, furthermore, physician members were now obligated to care for their former pay patients as members of the Multnomah Association at the low net fees which the association was able to pay. Added to this was the fact that in order to meet the competition of other like organizations, it was necessary for the Multnomah organization to give coverage to certain executives who had incomes of more than $1800 a year.

A committee was appointed under the chairmanship of Dr. Karl Martzloff to investigate all hospital associations and especially the Multnomah organization. The survey was made under the personal direction of Mr. Ralf Couch, secretary of the University of Oregon Medical School, at a cost of some $900. The committee had complete access to the books of the Multnomah association and also went over the books of Industrial Hospital Assciation, but were denied access to the books of the National and other associations. This report, which became known as the Martzloff report, could distinguish no essential difference between Multnomah Industrial Health Association as operated and the commercial hospital associations, and advised
3989 against the continuance of the approval the council had given the association.

This report definitely divided the members of the society into two groups, those who were opposed to hospital associations and contract practice in any form and those who believed that an organization such as the Multnomah, with

the backing of the county society and meeting the organizations on their own ground, could drive the other commercial organizations from the field. The council took action and withdrew its approval from Multnomah Industrial Health Association. A considerable minority disapproved of this action and, in accordance with the provisions of the constitution and by-laws, the questions were referended to the annual meeting to be held on December 18, 1935.

At this meeting, the largest attended annual meeting the society has ever held, the late Dr. J. Tate Mason, then president-elect of the American Medical Association, was the chief speaker. Interest was at such a high heat that it was felt the welfare of the society would be promoted by not voting on the question at that time, but by letting it come before the members at an adjourned session. It was, therefore, voted that an adjourned meeting should be called at such a time as President Brooke deemed advisable. It seemed, on a standing vote on the question, that those members who had interpreted the code of ethics most strictly were supported by members of the hospital associations other than the Multnomah and by other physicians doing contract work. The Multnomah Association members voted almost alone for their program. In the succeeding months the arguments were frequent and at times spirited, and personalities were allowed to enter into the discussion and into the society's publication.

Another matter which has added to the confusion is the fact that Multnomah County Medical Society has upon its roll several members who for various reasons should be dropped. One, for instance, has had his license revoked. Under the present laws it would take about two years and much money to drop him, should he resist loss of membership to the extent of appealing to the civil courts. It is generally agreed that several less flagrant violators should also be disciplined. The by-laws, therefore, were amended by the council to provide that on December 31 of each year all members of the society shall lose their membership in the society except the newly elected council and other officers. These few select holdover members shall restore to full membership all previous members whom they deem not unworthy of membership and shall notify those members who are believed not to be entitled to reinstatement of such action. These may then show cause why they should not have been denied continuing membership.

Some of the members unfortunately conceived the idea that the amendment was intended to drop all those who

belonged to certain organizations, but those who initiated this movement disclaim any such intent. It is intended that this by-law shall affect only those very few whom almost every member of the society, knows to be outside the circle of ethical respectability. At the next annual meeting the constitution will be amended so as to put the provisions of this new by-law into effect.

Following a consultation with his advisers, President Banner R. Brooke called the recessed session of the annual meeting for July 1, and Dr. Morris Fishbein, editor of *The Journal of The American Medical Association,* was invited to address the society on the subject of medical ethics. Dr Fishbein made a most masterly address, tracing the history of medical ethics from ancient times and reviewed the past record of the medical profession in its services to humanity without the intervention of a third party, organized or otherwise. Upon a secret ballot vote of the members present on the two questions involved, namely, the acceptance of the Martzloff report and the withdrawal of the approval which had been given to Multnomah Industrial Health Association, the council was sustained in both instances.

There is no thought to penalize those who became members of Multnomah Industrial Health Association through inadvertency or errors in reasoning, or the stringency of the financial situation or perhaps some other reasons, nor is it intended that the organization shall not complete its present contracts, but rather it is proposed that no further contracts shall be made so that, when present contracts are fulfilled, the organization may disband.

In all this discussion one is struck by the utter sincerity and honesty of both sides. Unforunately, this controversy within the medical society has made the public health insurance-minded in a way that may not bode good for the profession nor for the public itself. Such has been the experience in other countries where the high standard of medical service, as is given in America, cannot be maintained under conditions where the physician-patient relationship is disturbed.

3990 Anything that can be done to make up for the errors that have been made will to that extent reestablish amity and good will between the members. The absolute living up to promises for the future by both sides to the controversy, especially in the matter of making a clean sweep of all hospital associations, will be necessary. When this has been accomplished, members of Multnomah

Industrial Health Association may be credited with having made an unpromising situation so distasteful that it had to be corrected. The council of Multnomah County Medical Society, being constituted of outstanding members in whom the profession has confidence, should be able to guide the profession correctly in the matters which come before it. Any plan which is put into effect must have its approval. Its judgment, while safeguarding the members of the medical profession, will guarantee to all patients the highest type of medical services that can be rendered.

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THE FOURTEENTH AMERICAN MEDICAL DIRECTORY

The medical profession ought to realize the importance of the last edition of the American Medical Directory. This volume, the result of two years continuous labor, presents a wealth of information concerning the medical profession of our country, with varied detailed specifications unobtainable elsewhere. It contains the names of 183,312 physicians, with 13,157 added to the last issue, 7,684 names having been removed because of death. Thirty-two states show an increase of physicians, while twelve show a slight decrease.

In addition to this listing of names and addresses, specialties are included, indicated in connection with each recorded name. There is also an alphabetical list of all physicians of the country with their residence addresses. In addition to this manifold information concerning individuals, there are sections including medical practice acts, boards of health, medical examiners and other allied activities. Also there are lists of hospitals, sanatoria and related institutions with detailed specifications for each. No one volume exists from which can be obtained such a wealth of information regarding the medical profession of the United States and its dependencies and Canada. This volume should be available for all practitioners, especially officers of medical organizations.

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Plaintiff's Exhibit 209

3992 To the Council of the Multnomah County Medical Society:

Your Committee on the Study of Medical Care for Low-Income Persons submits the following report.

1. The Committee Assignment

Our assignment in this study according to your instructions was three-fold:

1. To study existing differences of opinion concerning the policies of the Multnomah Industrial Health Association;
2. To study and submit recommendations for the application of the "Ten Principles" of the American Medical Association to local conditions; and
3. To consider such other problems in connection with the medical care of persons with incomes below the "comfort level" as the committee deemed desirable.

2. Studies Forming the Basis of This Report

The factual information contained in our report and the conclusions and recommendations made are based largely upon data collected and presented in the form of a series of reports by Mr. Ralf Couch who was selected by the committee with the approval of the Council for this purpose. We list below the titles of the several reports prepared by Mr. Couch and used as a source of information by your committee.

1. Scope of Investigation.
2. Investigations and Studies to be Made.
3. Statistical Study of the Multnomah Industrial Health Association.
4. Resolutions and Actions of the Council.
5. Proposed Questionaire to the Members.
6. Statistical Study of the Industrial Hospital Association.
7. Preliminary Agreement Signed by Physicians Starting the Multnomah Industrial Health Association.
8. Statistical Compilation of a Questionaire.

9. National and Local Material on Family Subsistence Budgets.

10. Detailed Comparison of Statistical Data of the Multnomah Industrial Health Association and the Industrial Hospital Association.

11. Financial History of Hospital Associations in Oregon.

12. Report on The Pumphrey Company Hospital Association.

Copies of these reports are appended to our report in order that the Council may refer to them when our report is under consideration.

3993 *Analysis of the Multnomah Industrial Health Association.*

Our analysis of the Multnomah Industrial Health Association has led to the following findings:

1. It has made no study to determine the amount of premium income necessary to carry on its function properly. (Page 18, Report No. 3) Rates have been fixed by arbitrarily adopting those previously placed in effect by the commercial hospital associations. The consequence of failure to establish adequate rates is reflected in the low compensation received by physicians.

2. It has made no study to fix the maximum income level which would define eligibility as a "low-wage" earner. The maximum level was first arbitrarily fixed at $1500 per year and later arbitrarily raised to $1800 per year. (Page 18, Report No. 3). By failing to fix a sound and definite income level, it has brought under a so-called "low-wage" earner's plan many persons; for example, executives and schoolteachers, who have heretofore been willing and able to support regular private practice.

3. Its operations have resulted in a decreased income for that part of the profession within the Multnomah Industrial Health Association from patients who are able to pay customary fees and in the loss of some of these patients by doctors outside the Association. (Summary of Completed Questionaires, Report No. 8). The coverage of this group of per-

sons by the Association has deprived their family physicians of a source of income to which the latter are entitled and were receiving until the advent of the Association. The effect of this situation is doubly vicious in that competition of the worse type is created when patients change doctors not on consideration of professional ability but on the basis of cheap service. Under such circumstances both physicians suffer; the doctor whose patient leaves him, and the doctor who receives the patient and provides professional care for a fee which is inadequate to supply him a decent living, to say nothing of allowing him time and means to carry on his studies.

3994 4. It has not produced a wider distribution of patients nor been of material help to young physicians entering practice. (Pp. 26-28, Report No. 3) This conclusion is evident from the figures on Page 26 covering the last 6 months of 1934 which show that 22 physicians (12 per cent) of the entire panel of 181 physicians received 50 per cent of the fees and, what is even more striking, that 9 physicians (5 per cent) received 30 per cent of the fees. On the other hand, the 35 physicians (18.4 per cent) of the entire panel of 181 physicians who have been in practice 10 years or less received only 14.7 per cent of the fees. It is thus apparent that a plan of this type cannot materially assist the young physician entering practice nor the older physician whose volume of practice is below average. On the contrary, just as in ordinary private practice, the successful physician continues so.

5. Its operations have had no appreciable effect on the proprietary hospital associations and its subscribers have been largely drawn from groups of persons who have never before been brought under a scheme of contract medicine. (Pp 10-12, Report No. 3) The report shows that for the period ending December 31, 1934 after almost two years of operation, the Association had obtained only 15.2 per cent of its subscribers or 7.5 per cent of its contracts from other hospital associations. As there is always a small turnover in contracts due to dissatisfaction, the conclusion seems inevitable that the Association has had a negligible effect on the proprietary associa-

tions. On the other hand, it is equally apparent that the Association has furthered the extension of contract practice, which has heretofore been regarded as an evil, inasmuch as 85 per cent of its subscribers represented new contract patients.

3995 6. Its administrative and sales costs have been among the highest of all hospital associations and its return to physicians the lowest. (Page 12, Report 11). If the total disbursements of the Association for the last 6 months of 1934, 21 per cent were for fees of member physicians, while 40 per cent were for administrative and sales overhead. (Page 9, Report 3). It might be said in extenuation that the cost of selling the Association's service will decrease as the organization becomes more firmly established. While this may be true, it does not necessarily follow, for an examination of Report 11, page 7, shows that the Physicians and Surgeons Hospital Association of Salem, which is a physician-controlled corporation, doubled its administrative costs in 1934 as compared with 1932, while its total income and disbursements to member physicians did not increase correspondingly. From the figures in Report 11, page 11, it will be seen that payments to physicians as compared to total expenditures is lowest (29 per cent) in the Multnomah Industrial Health Association and the highest in the Pumphrey and Industrial Hospital Associations. The same tabulation indicates that the Multnomah Industrial Health Association is among the four organizations in the state with the highest administrative and sales expense as compared to total disbursements.

7. It is an independent corporation organized and operated after the pattern of the commercial hospital associations and, while operating with the apparent, nominal approval of the Society, is actually not under Society Control. It seems apparent that any plan changing the method of delivering medical service to any class in the community, affecting, as it must, the entire medical profession, should be under close and immediate supervision by the local medical society. The defects developed in the Association have been due in considerable part to the absence of such control.

3996 8. It includes only a part of the membership of the Society. Inasmuch as the problem of providing medical care to the "low wage" earner is a problem traditionally assumed by the entire medical profession, all members should participate in any special plan adopted to serve this group. Furthermore, all physicians have some patients in the "low wage" group and most physicians depend largely on this group for their clientele. The bringing of such patients under a plan such as the Association offers without having all members of the Society participating, seriously affects the practice of the non-participating physician, as well as the participating physician.

9. It does not provide care for the dependents of the "low-wage" earner. By following the pattern of the commercial hospital associations, which provide care for the employed members of the family only the Association has not touched the problem of the family illness. This is a larger phase of the economic problem of the "low-wage" earner than that of his own personal care in sickness.

10. It impresses upon the public the idea that adequate medical service can be obtained for a very low price and creates the impression that the usual charges are exorbitant. This consequence follows from the low rates charged and the selling methods employed which lead the public to believe that the physicians represented by the Association must be engaged in a lucrative commercial enterprise, inasmuch as they employ salesmen to "sell" the public on medical service under the stated conditions.

3997 11. It tends to restrict the quality of service rendered the recipient of medical care. This result appears inevitable under any completely prepayment plan where nominal rates are charged. A collision occurs between the economics of the situation and the standards of scientific medicine when the service rendered the patient is limited by a sum prepaid by him. The participating physician becomes discouraged and loses interest when he finds that the Association desires to eliminate diagnostic and treatment procedures which his scientific training has taught him to be necessary.

12. It has produced in operation a marked increase in "morbidity" among its subscribers over what is probably a normal morbidity among this group under regular private practice. This consequence illustrated another well-known feature of prepaid or insurance plans. It will be seen by reference to Report No. 3, Page 18, that during 1934 "patients" numbered 81 per cent of "subscribers", and this in spite of the fact that all "subscribers" were not under coverage for the entire period. It is apparent that the Association's subscribers do not look upon their coverage as "insurance" against some definite medical contingency, but as a contract for service which is to be used almost immediately as soon as it is placed in effect and as frequently thereafter as the slightest provocation will warrant.

3998 13. Its methods of obtaining subscribers violate "The Principles of Medical Ethics" in that paid solicitors are employed, advertising literature listing the physician-members used, and prospective subscribers sought by these methods are informed that the Association has the official approval of the Multnomah County Medical Society (Pp. 9, 10, Report No. 3) This situation places the Society in the position of approving the violation of its own Constitution and By Laws of which "The Principles of Medical Ethics" are a part. It should be pointed out that the prohibition against advertising and solicitation in "The Principles" applies equally to organizations, groups of physicians, and individual physicians.

Conclusions Concerning the Multnomah Industrial Health Association

While your committee believes that the Multnomah Industrial Health Association has been an interesting experiment, it is of the opinion that the following features of its operations as set forth in detail in the foregoing analysis makes its continuance detrimental to the best interests of the community and the medical profession:

(1) The absence of sound premium rates;

(2) The absence of a definite income level;

(3) The decreased income to physicians from regular private patients with incomes above the "comfort"

level placed under contract and the diversion of many such patients from their former physicians;

(4) The failure to effect a wider distribution of patients as to assist the younger physicians;

(5) The failure to draw its subscribers from groups already under coverage by the proprietary hospital associations;

(6) The high administrative and sales cost and the low return to physicians;

3999 (7) The adoption of the commercial hospital association pattern of private corporation over which the Society has no actual control;

(8) The absence of participation by all members of the Society;

(9) The absence of provision for the care of the "low-wage" earner's family;

(10) The impression created on the public that adequate medical service can be obtained at a very low price and that customary charges are exorbitant;

(11) The tendency to restrict the quality of medical service;

(12) The production of a marked increase in "morbidity" among subscribers;

(13) The violation of "The Principles of Medical Ethics" arising from the employment of paid solicitors and the use of advertising literature listing the physician-members.

Your committee believe that these features of the Multnomah Industrial Health Association are all extremely undesirable, but regard the use of solicitation and advertising in violation of "The Principles of Medical Ethics" and our Society's Constitution and By Laws as the most vital defect.

The Proprietary Hospital Association

Your committee believes that the proprietary hospital associations possess all the objectionable characteristics which have developed in the Multnomah Industrial Health Association as well as some additional features in contravention of the principles of high-type medical practice.

Among these latter features may be mentioned the practice of providing "courtesy" service to executives for the purpose of creating good will with organizations whose workers are under contract. This "courtesy" service often includes medical, nursing, and hospital care in a major illness.

4000 *Recommendations Concerning Hospital Associations*

Your committee recommends that disapproval be expressed of the affiliation of members of our Society with commercial hospital associations, including the Multnomah Industrial Health Association, in violation of "The Principles of Medical Ethics" and the Society's Constitution and By Laws, to the extent of expulsion from the Society, after present outstanding contracts have expired; except that members be permitted to care for persons in isolated districts on a contract basis where proper medical service is not available under customary conditions, provided such contracts have been previously submitted to and approved by the Board of Censors.

Your committee further recommends that the Council institute immediately a study of the present practice of the hospitals in granting special rates to commercial hospital associations below the rates charged the private patients of our members, thus in effect subsidizing these associations at the expense of our patients.

Your committee further recommends that the hospitals be requested to make membership in the Multnomah County Medical Society one of the requirements for staff membership.

Brief Analysis of Members' Questionaires

Your committee felt that sound conclusions on many of the questions to be considered under its assignment could not be reached without obtaining the point of view of the membership. For this reason a comprehensive questionaire was sent out early in the course of our investigations.

We believe that the subject-matter of the replies is of such significance that a summary of the answers on the important points is supplied below.

1. A large majority expressed the belief that the medical profession owes a moral obligation to the community to provide some plan for the medical care of the "low-wage" earner.

2. An overwhelming majority favored some form of prepayment plan for the "low-wage" earner.

4001 3. A large majority opposed making such a plan available to anyone irrespective of income.

4. A majority expressed the opinion that the maximum income level defining the "low-wage" earner should be adjusted with the size of the family and fixed at $70.00 per month or $840.00 per year for a single person and $90.00 per month of $1080.00 per year for man and wife.

5. A majority felt that even after a definite income level had been fixed, there would be danger of having this level raised by the managing force, even in an organization owned by physicians.

6. A small majority (54 per cent) expressed the opinion that the Multnomah Industrial Health Association would restore to the family physician patients formerly lost to proprietary hospital associations. This conclusion was apparently based on "wishful" thinking, since as we have previously pointed out only 15.2 per cent of Multnomah Industrial Health subscribers was taken from the proprietary associations. However, 75 per cent of the replies from members not participating in the Multnomah Industrial Health Association plan expressed the opposite opinion.

7. A majority (66 per cent) expressed the opinion that the Multnomah Industrial Health Association could compete successfully on a commercial basis with the proprietary associations. The facts developed in our investigations do not appear to support this opinion.

8. A majority believed that hospital associations jeopardize a high type of medical practice in this community.

4002 9. A majority expressed the opinion that the Multnomah Industrial Health Association should not be continued on a competitive, commercial basis. 17 per cent favored the complete discontinuance of the Association. This attitude is of considerable significance in that the questionaire was answered by 53 per cent of the membership of the Multnomah Industrial Health Association and by only 26 per cent of the non-members.

10. A majority expressed the belief that some type of organization should be continued on the basis of discharging a moral obligation to the community.

Defining the "Low-Income" Group

Your committee is of the opinion that the matter of eligibility to service under a special plan designed to meet the needs of the "low-wage" group is one of the most vital phases of the whole subject under consideration for the reason that a slight variation in the agreed upon income level would affect the relations between a large number of families and the medical profession when used in the administration of any new plan of medical practice.

From the standpoint of ability to pay for medical care, we may recognize three classes:

1. The group with incomes above the comfort level.

We are not particularly concerned here with this group as they receive and pay for medical care in the customary manner.

2. The indigent who can pay nothing for medical care.

We have given no special consideration to the problem of the indigent, except that we are impressed with the tremendous load carried by the medical profession in connection with the care of this group. At the present time almost the entire load of providing professional care to this group is borne by the physicians either in free service rendered in clinics and hospitals or in their private practice. Your committee is of the opinion that steps should be immediately taken to impress upon the public authorities that government should share at least a part of this burden.

4003 The standards of eligibility for medical indigence are of some significance to the problem of the care of the "low-wage" earner in that these standards fix the lower level of the "low-wage" group. As most organized free medical service is supplied by the University of Oregon Medical School Outpatient Clinic, we indicate below the maximum income levels for admissions to the Clinic:

Single Person	$540.00	per year
Man and Wife	720.00	" "
Man, Wife, and One Dependent	810.00	" "
Man, Wife, and Two Dependents	900.00	" "
Man, Wife and Three Dependents	990.00	" "

These limits may be said to fix the upper level of indigence and the lower level of the "low-wage" group in ous community.

3. The "low-wage" group who can pay something, but who cannot pay full customary fees.

In fixing a suggested maximum income level for the "low-wage" group, your committee has been guided by the studies of various economists which appear in Report No. 9, by the opinions expressed by the membership through the questionaire, and by their own experience in the local community. On the basis of these considerations your committee recommends the following table of maximum income levels as a concrete definition of the "low-wage" group:

Single Person	$ 800.00	per year
Man and Wife	1000.00	" "
Man, Wife, and One Dependent	1150.00	" "
Man, Wife, and Two Dependents	1300.00	" "
Man, Wife and Three Deendents	1450.00	" "

Fundamental Principles Which Should Underly a Plan of Medical Care for the "Low-Income" Group

Before undertaking to suggest a plan for the care of the "low-wage" earner, your committee is of the opinion that careful consideration should be given to certain fundamental principles which are essential to the maintenance of high-type medical practice. Once we are in agreement on these principles, they should be maintained at all costs in the development of the plan and its subsequent application to the "low-wage" group.

4004 1. The philanthropic motive should govern throughout and the plan should be considered solely as an attempt to carry out the centuries-old tradition of the medical profession to care for all classes of the community in accordance with their ability to pay.

2. The plan should be under the direct control of the Society.

3. All members of the Society should be permitted and encouraged to participate.

4. The benefits of the plan should be limited to the "low-wage" group as previously defined in terms of family income.

5. The plan should be available to the "low-wage" earner and his dependents.

6. There should be no competition with commercial organizations which seek to sell medical service to the "low-wage" group.

7. There should be no solicitation or advertising employed to bring the plan to the attention of the "low-wage" earner and the acceptance of the plan should be entirely voluntary on the part of those to whom it is offered.

8. There should be no associated plan of compensation for time lost from employment.

9. The plan should be limited to providing the professional services of the physician.

10. The patient should be required to purchase his own drugs and appliances.

11. The patient should be permitted to prepay only a part of the cost of professional services, the balance to be paid in cash when the service is rendered.

4005 12. The physician should be compensated on the basis of a percentage of his customary fee, which should be paid in cash by the patient at the time the service is rendered, this amount to be supplemented by an additional amount paid from the prepayment fund.

13. The hospitals should be requested to join together for the purpose of providing a limited amount of hospital care for a fixed monthly fee, (possibly similar to the Sacramento, California Plan) and, for an additional fee, to provide in cooperation with the clinical pathologists and radiologists all necessary x-ray films and laboratory service. (other than routine)

Final Remarks Concerning Changes in Medical Practice

Your committee feels that in concluding its report, it may with propriety make several observations on the situation in medical practice which has prevailed for the past few years and which may continue in some degree during the near future.

It seems likely that until general economic conditions improve, there will be considerable pressure from sources both within and without the medical profession looking to-

ward the partial abolition of private practice through some scheme of voluntary or compulsory insurance for large sections of the population. We are more concerned over this trend within the profession itself.

There are at all times in the medical profession, as in all other professions and occupations, a group who for one or another reason have economic difficulties which they find it difficult to surmount. This group is, however, a comparatively small one and cannot form the main object of attention from the organized medical profession. If this group should become our main concern, then some form of contract practice with fixed wages would be, desirable so that all physicians might be on dependable salaries irrespective of individual aptitude and initiative. This is the trade union idea whereby the slowest man on the job sets the standard of work performance for the entire group. This leveling process is one of retardation emphasizing inability rather than ability and tends to level off at a low plane not a high one.

4006 This is only one of several aspects in which a profession differs from a trade union. In a profession the emphasis is upon ability and integrity. Each individual is supposed to do his very best at all times. This applies to his actual work as well as to the time he must spend in study if he is to keep himself informed. Under such a tradition the tendency is one of constant improvement and it is inevitable that the laggard be left behind. By this we do not mean that every competent physcian is a marked financial success. Ordinarily, however, he manages to make his way and adheres to the traditions of our profession.

The point of these observations is that plans for altering medical practice cannot with safety to the medical profession as a whole be determined on the basis of the relief of physicians with low incomes. It is well to bear in mind that the traditions of our profession of which our code of ethics is merely an expression, are the outgrowth of years of experience by our predecessors. These men also were faced by privation and problems that few of us have ever experienced. They were not mere theorists, but of the school of "hard knocks" and practical experience and long before our time recognized that certain tendencies and practices by some of the short-sighted members of the profession were inimical to the ultimate welfare of our patients and were therefore considered unethical.

We believe that new plans of medical practice should only be experimented with under careful observation and

control and that every effort should be made to uphold the time proven principles of our profession. All changes should be premised on the advancement of the public welfare with the philanthropic motive dominating. Even such changes should be required to square with the long established principles which have elevated medical practice to its present high position in our community.

(Signed) Otis F. Akin
(Signed) Noble Wiley Jones
(Signed) W. K. Livingston
(Signed) Karl H. Martzloff, Chairman
(Signed) W. F. Patrick
(Signed) Raymond R. Staub
(Signed) A. M. Webster

Plaintiff's Exhibit 210

4007

Report #1.
Copy 4—Dr. Jones

A PRELIMINARY REPORT

to the

Special Committee of the Multnomah County Medical Society Formed for the Purpose of

STUDY OF MEDICAL CARE FOR A LOW INCOME GROUP

January 15, 1935.

Reason for Formation of Committee

A study of the minutes of the previous meetings of the committee, together with its communication from the Council of the Multnomah County Medical Society, indicates the purpose of the formation of the committee to be to conduct a study into Medical Care for Low-Income persons, with particular reference to the Policies and Practices of the Multnomah Industrial Health Association, the necessity for which has arisen because of (1) questions arising as to eligibility to benefits of medical service furnished by the Association through its periodic prepayment health insurance plan to a so-called "low-income" group of the community; (2) to study the recommended "ten-principles" of

the American Medical Association as they apply to policies and practices of sickness insurance organizations in the local community, and (3) to study the so-called "comfort level" in Portland and make recommendations as to eligibility of a group to receive benefits of medical service at reduced rates, through whatever medium they become available.

PHASES OF THE STUDY

All of the studies of this problem are interlaced under the general heading of sickness insurance as a whole. Because of this fact, in order to accomplish orderly and just conclusions, it is necessary to recognize phases of
4008 such a study as follows:

A. The inclusive term, sickness insurance as a whole, compulsory and voluntary, together with medical or governmental supervision.

B. A narrower phase, the study of sickness insurance on periodic payment plans operated by physicians or by laymen and a plan of determining eligibility for medical service at reduced rates through the local medical society or other organizations, and,

C. A specific study into the policies and practices of sickness insurance organizations in Portland—the proprietary associations as fully as it is practicable to obtain the information—but in particular the policies and practices of the Multnomah Industrial Health Association, as follows:

(1) To review its policies and determine their correlation with the standard ("ten-point" measure) of the American Medical Association;

(2) To investigate the practices of the Association to determine whether or not they are in conformance with its policies;

(3) To analyze the operations of the Association during the last three years from the standpoint of:

(a) The medical profession as a whole in Multnomah County.

(b) The physicians who are members of the association.

(c) Physicians who are not members of the Association.

(d) Recipients of the service..

(e) Competing so-called "proprietary" associations

(f) Financial records

(g) Articles of incorporation

(h) Changes in policies

(i) Study of by-laws

(j) Sales methods and sales organization

(k) Study of minutes of meetings of Trustees and Directors

(l) Publicity policies

(m) Methods employed by Association in arriving at present premium level

(n) Studies made by the Association into costs of living in Portland

4009 (o) Method of determining comfort level scale in use in letting contracts.

(p) Undesirable practices necessitated in competing with "proprietary" health associations.

(q) Other matters that will arise during investigations

It is assumed that an investigation into the practices of the Association is to be confidential and open to no one except the committee or persons authorized by the committee to receive such information.

(4) To obtain a cross section opinion directly from the general membership of the Multnomah County Medical Society with a view to presenting all problems to the committee arising out of the operations of Multnomah Industrial Health Association, proprietary Industrial Health associations and/or other pre-payment insurance plans for furnishing medical service to low-income groups at reduced rates.

(5) To conduct a study of incomes and costs of living in Portland and recommend eligibility limitations for a group wishing a contract with the

Health Associations to furnish (or receive) medical service at reduced rates.

(6) To formulate and make recommendations resulting from this specific study.

In fairness to the Multnomah Industrial Health Association and proprietary health organizations, it is important that the three phases of the whole problem of sickness insurance be recognized for separate studies and while they may be interrelated, confusion as to the issues at hand and purposes for which the special committee was established may be lost in an attempted all-comprehensive study.

4010 METHOD OF CONDUCTING THE INVESTIGATION

For the purposes of investigation and study of any of the above problems the committee must consider (1) scientific material already available, such as reports of the American Medical Association, governmental reports on living costs and index numbers, books written upon this subject, etc., all of which if interpreted in terms of local conditions may be of assistance in working out decisions and recommendations.

It is also necessary to (2) obtain information unknown to the committee such as policies and practices of local organizations, opinions of the local medical profession, determination of methods of obtaining general information as to reactions of all those to be affected by the recommendations and changes, if any, and other similar data.

Such information is to be obtained by personal interviews, questionnaires and review of records of organizations affected, if available.

Information requested should be pertinent to the purpose of the investigation, fairly obtained with a full understanding of the use to which it may be put and most important that it should be sought only after a clear understanding of what is needed together with a detailed plan for obtaining it.

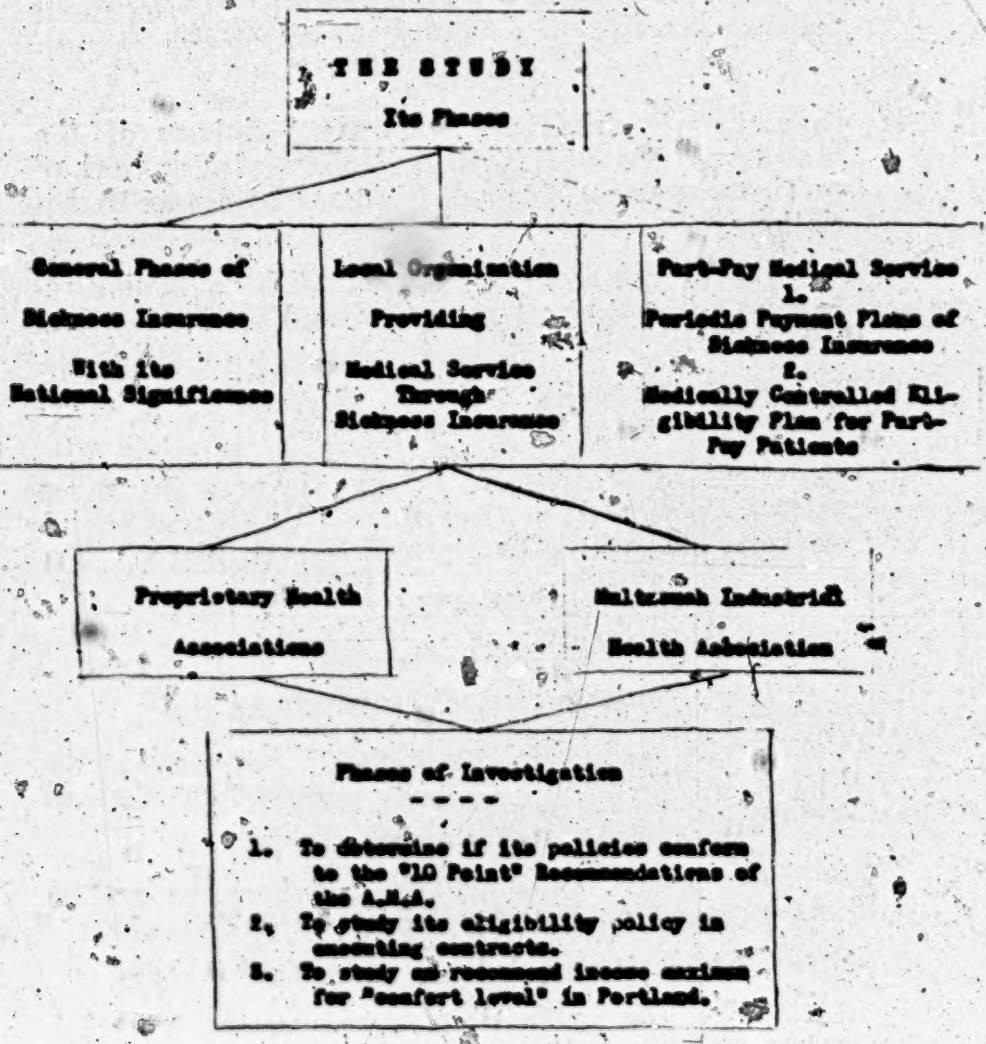
The next step in the study will probably be to outline in detail the material to be sought and method of obtaining it.

It would be ill advised to rush the investigation at this stage until there is detail information of what it is hoped to obtain. Then, investigation should not be started until the committee approves such procedures.

Report approved by the Committee at its meeting, Monday, Jan. 14, 1935.

DIAGRAM OF A STUDY OF SICKNESS INSURANCE ORGANIZATIONS IN PORTLAND WITH PARTICULAR REFERENCE TO THE MULTNOMAH INDUSTRIAL HEALTH ASSOCIATION

Conducted by a Committee of the Multnomah County Medical Society


THE STUDY
Its Phases
General Phases of Sickness Insurance With its National Significance
Local Organization Providing Medical Service Through Sickness Insurance
Part-Pay Medical Service
1. Periodic Payment Plans of Sickness Insurance
2. Medically Controlled Eligibility Plan for Part-Pay Patients
Proprietary Health Associations
Multnomah Industrial Health Association
Phases of Investigation
1. To determine if its policies conform to the "10 Point" Recommendations of the A.M.A.
2. To study its eligibility policy in executing contracts.
3. To study and recommend income maximum for "comfort level" in Portland.

Plaintiff's Exhibit 211

4012

Report No. 2.
Copy No. 4
Jan. 21, 1935
Dr. N. W. Jones

PRELIMINARY REPORT NO. 2.

Special Committee of Multnomah County Medical Society
Medical Care for Low Income Groups

INVESTIGATIONS AND STUDIES TO BE MADE

Investigations

(Section)

I. Health Associations in Portland furnishing sickness insurance to low-income groups with an analysis of policies, practices and operating experience.

Studies

II. Opinions of physicians who are members of the Multnomah County Medical Society with regard to service dispensed through Sickness Insurance Associations.

III. Study of living costs in Portland with particular reference to low-income groups of and below "comfort level".

IV. Study of "10 point" measure of American Medical Association from local standpoint.

V. Reactions of others affected by Sickness Insurance such as patients, employers, public officials, social workers, etc., who often formulate such plans.

VI. Summary

A summary of all materials

VII. Conclusions and Recommendations

Conclusions and recommendations of the special committee to the Council of the Multnomah Medical Society

* * * * * * * * *

While the work of the committee ends here, an outline would not be complete with out indicating the following:

Methods of Applying Council Recommendations

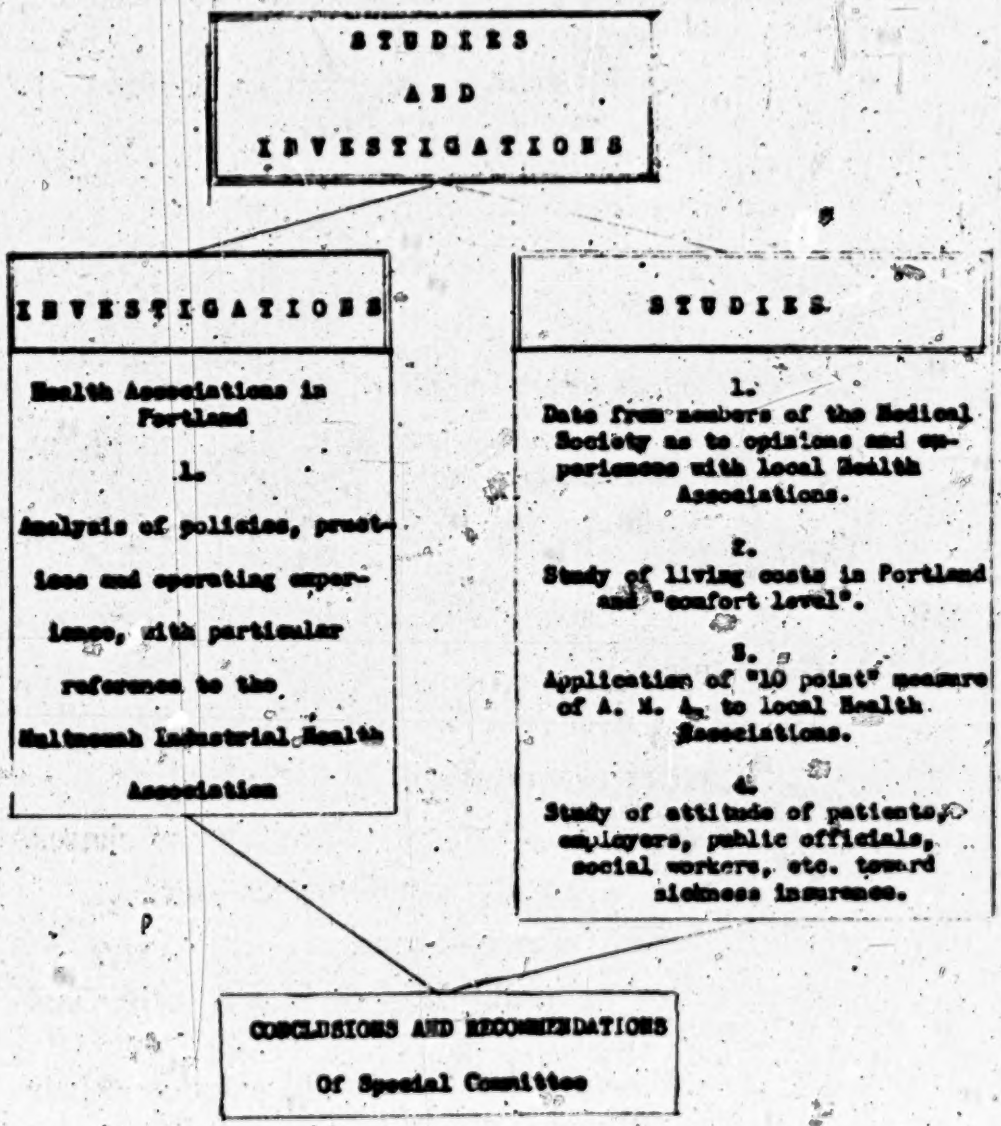
A detailed study of ways and means of applying recommendations of the Council

Preliminary Report No. 2.

SPECIAL STUDIES AND INVESTIGATIONS TO BE MADE

Special Committee of the Multnomah County Medical Society

January 21, 1938.


STUDIES
AND
INVESTIGATIONS
INVESTIGATIONS
Health Associations in Portland
1.
Analysis of policies, practices and operating experience, with particular reference to the Multnomah Industrial Health Association
STUDIES
1.
Data from members of the Medical Society as to opinions and experiences with local Health Associations.
2.
Study of living costs in Portland and "comfort level".
3.
Application of "10 point" measure of A. M. A. to local Health Associations.
4.
Study of attitude of patients, employers, public officials, social workers, etc. toward sickness insurance.
CONCLUSIONS AND RECOMMENDATIONS
Of Special Committee

SECTION I

DETAILS OF INFORMATION SOUGHT AND ORGANIZATIONS TO BE INVESTIGATED

* * * *

I. PURPOSE OF THE INVESTIGATION

(Outlined in Preliminary Report No. 1).

II. PORTLAND ORGANIZATIONS TO BE INVESTIGATED

A. Multnomah Industrial Health Association, Dr. E. P. Owen, Pres., 607 Woodlark Bldg.

B. National Hospital Association, C. C. Bechtold, Sec., 400 Mohawk Bldg.

C. Contractors—Employes' Hospital Association—T. B. Curren, Pres., Security Bldg.

D. Employees Hospital Association, L. F. Smith, Pres., Terminal Sales Bldg.

E. Industrial Hospital Association, W. T. Kirk, Sec., Medical Arts Bldg.

F. Prudential Hospital Association, A. E. King, Pres., 350 Morgan Bldg.

G. Pumphrey Hospital Association, C. B. Pumphrey, Pres., Wilcox Bldg.,

H. C. H. Weston Company, C. H. Weston, Pres., Times Bldg.

III. GENERAL INFORMATION

A. *Corporate*

1. Official name.
2. Type of organization.
3. Names of stockholders and number of shares.
4. Names of Directors or Trustees—terms.
5. Names of Officers—terms.
6. Number of meetings of directors during last year.
7. Are directors or officers paid extra for their services in this capacity?

8. Is control entirely in hands of medical profession? (1)
9. Net profit or loss experience.
10. Dividends paid regularly?

B. *Management*

1. Managing director. (2)
2. Sales director and salesmen
4015 3. Head of medical and surgical service.
4. Names of committees, if any.
5. Head of credit department.
6. Claim agent.
7. Name of attorney for association.
8. Other departmental heads.
9. If any concerned in management are physicians on panel, do they receive extra compensation for service?
10. Does management have right to place restrictions on patients in their contact with physicians? (2)

C. *General*

1. Approval of local medical society.
2. Attitude of directors of association toward this study.
3. Attitude of managing director toward this study.
4. Geographical area covered by activities.

IV. HISTORICAL

A. Short history of association:

1. Motive for starting.
2. Early organizers.
3. Have motives changed since early period?
4. Other data.

V. ANALYSIS OF FINANCIAL STATEMENTS, 1934 —COMPLETE DETAILS

A. Balance sheet.

1. Admitted assets.
2. Liabilities and capital.
3. Net surplus.

B. Profit and Loss statement.

1. Income.
2. Expenditures.

C. Receipts and disbursements—detail.

D. Analysis of surplus.

E. Analysis of reserves.

F. Dividends declared over period of years.

G. Sinking funds and purposes.

H. Is there an annual audit? ..... By whom? .....

4016 VI. ADMINISTRATIVE AND SALES OVERHEAD

A. Total cost: (a) Administrative ..... (b) Sales .....

B. Number of compensated employees: .....; Administrative ..... Sales .....

C. Ratio of Administrative and Sales expense to total disbursements.

VII. SALES POLICIES

A. *Memberships*

1. Is number of physician memberships limited: .....? Why .....?
2. Who solicits for new members?

B. *Contracts*

1. General groups not solicited.
2. Basis of compensation to salesmen.
3. If on percentage basis, indicate rate.

VIII. Undesirable Practices Necessitated by Competing Associations

A. Obtain list of undesirable practices each association feels the others in the field engage in.

IX. Publicity Policies

A. Public addresses.

B. Newspaper advertising.

C. Radio talks.

D. Direct mail.

E. Hand bill distribution.

F. Distribution of literature through firms.

G. Does an advertising agency have charge of advertising?

X. Epidemics

A. Plan for meeting.

B. Reserves set aside annually.

C. Adequacy of Fund or Reserves.

D. Past experience with epidemics.

XI. Data Concerning Contracts

A. List of firms with numbers for each.

B. Total individuals covered.

C. Largest organization coverage ..... smallest ..... average .....

D. Taken from other health associations—names of firms, members and association taken from.

4017 E. Per cent of individuals taken from other associations compared to total coverage.

F. Per cent of contracts taken from other associations compared to total contracts.

G. Classification of contracts:

a. Industrial	1. Laborers	*Size*
b. Associations	2. Skilled workmen	I–Up to 5 II–6 to 10
c. Firms with widely scattered employes	3. Clerks	III–11 to 25 IV–26 to 50
d. Small firms	4. Semi-professional	V–51 to 75 VI–76 to 100 VII–Over 100

H. List of contracts never under coverage before.

I. Contracts lost to other associations—names of firms and numbers.

J. Contracts cancelled by State Industrial Accident Commission.

XII. Scope of Medical Care or Benefits, With Limitations

Limited "Contract" Coverage

A. Ambulatory care—office visits.
B. Care in the home.
C. Medicines and accessories.
D. Consultation service.
E. Specialists care.
F. Emergency care.
G. X-ray diagnosis
H. Clinical laboratory findings.
I. Physical Therapy.
J. Preventive medical service.
K. Hospital coverage.
L. Ambulance service.
M. Nursing
N. Legal service.
O. Dental service.
P. *Cash benefits* (7)
   1. Permanent disability.
   2. Temporary disability.
   3. Burial benefits.
   4. Death claims.
Q. *Excluded services*
   1. Insanity.
   2. Pregnancy and accompanying disorders.
   3. Tuberculosis.

Limitations on Each

4. Conditions due to use of:
   a. Narcotics.
   b. Intoxicants.
5. Venereal diseases.
6. Conditions existing prior to coverage.
7. Chronic diseases.

R. May patient select portion of coverage when full premium paid?

4018 "Full" Coverage Contracts

A. Indicate coverage.

B. How do provisions differ from above, limited coverage.

XIII. Hospital Service

A. Is hospital service a part of coverage?

B. Who decides "qualified" hospitals?

C. Do approved hospitals have "medical control"? (5).

D. Does patient have a choice of hospitals?

E. Limitations on length of service.

F. Other restrictions.

XIV. Premium Rates

A. Were studies made to determine premium level?

B. Were rates set because of necessity of competition?

C. Are premium rates high enough for proper coverage?

D. Is there a premium scale according to income?

E. Is the scale by occupational hazards?

F. Do employers contribute—list of exceptions.

G. List of contracts where an employee only, pays premium.

XV. Collection of Premiums

A. Deducted by employer?

B. Checks made to association by individuals in firms?

C. Delinquent payment experience.

XVI. Statistical for Last Fiscal Year

A. Average number of visits per patient:

1. Office.
2. Home.
3. Consultation.

B. Average days in hospital per patient.

C. Average x-ray examinations per patient.

D. Ratio of "patients" to members covered, *numbers*

XVII. Financial Eligibility to Service (9)

A. Policy.

B. Studies made in determining level.

C. Reasons for making exceptions to those above "level".

4019 D. Who authorizes exceptions?

E. List of exceptions with estimated incomes.

F. Are factors other than "income" considered in deciding level?

G. Investigation by "sampling" individual incomes to determine whether only those under "comfort level" are served.

XVIII. Eligibility to Service Under Contracts —(Non-Financial)

A. Employee only?

B. Families?

C. Does association have a minimum for size of organizations who may obtain contracts?

D. May individuals in firms reject services?

E. Rejection for groups for occupational, moral or other reasons.

XIX. Qualifications for Physician Membership in Association

A. What are qualifications?

B. Who approves qualifications?

C. Are all qualified physicians permitted to give all types of service? (8)

D. Who determines those eligible as specialists on panel.

E. Are chiropractors, osteopaths, naturopaths, etc. admitted to panel?

F. Could any qualified physicians obtain membership?

XX. Organization of Medical Staff

A. Attending.

B. Consulting.

C. Other.

D. Rules for each.

E. Does all of staff own stock?.....Required or voluntary.....?

F. Is it the policy to classify members of staff both as "Attending" physician and "consultant"?

XXI. Abuses to Association by Physician Members

A. Over treatment.

B. Padding of statements.

1. Method of checking.

C. Collusion between "attending" physician and "consultant".

D. Use of expensive unnecessary drugs.

XXII. Selection of Physician by Patient (3)

A. Method of selecting physician from panel.

B. Advice given from Administration office as to selection.

C. Is there a geographical suggestion for home visits? visits?

D. Is more than one physician on case?—(not in consultation)

E. Experience in "shopping".

F. Limitations on selection of physicians by patient.

G. Who advises as to qualifications of physicians?

H. Does this plan give patient confidential relationship between patient and a "family physician"? (4)

XXIII. Complaints by Recipients of Service

A. Are complaints taken up with attending physician:

1. By lay administration.
2. Medical committee.
3. Medical director.
4. Other recourse.

B. Number of law suits to recover, classify by causes.

XXIV. Analysis of Payments to Physician Members

A. Division as to members in general. Any individuals receiving large proportions.

B. Division as to general practitioners and specialists.

C. Schedule of rates.

D. Method of paying physicians:

1. Salary.
2. Per capita.
3. Basis service rendered.
4. Dividends or bonus.

XXV. General Questions for Directing Head of Association

A. Would you indicate to what extent you believe your organization has interfered with the private practice of physicians in Portland?

B. Do you favor limiting coverage on contracts to individuals of low-incomes below the "comfort level"? State maximum for incomes.

C. Would your organization cooperate with the medical profession by permitting a review, by a disinterested committee of the Medical Society, of all existing and future contracts to determine if they only reach the low-income groups?

4020

SECTION II

Information to be Sought Through Members of Medical Society

I. Members of Multnomah Industrial Health Association Concerning Reactions to:

A. Own organization.

B. Other health associations.

II. General Membership of the Medical Society

A. Sickness insurance through local organizations:

1. Multnomah Industrial Health Association.
2. Proprietary health associations.
3. Advisable future procedures by medical profession along these lines.

SECTION III

Study of Living Costs and "Comfort" Level in Portland

I. Data Already Available:

A. Statistics U. S. Bureau of Labor.

B. Study Home Economics Extension Service—O. S. C.

C. Economic Principles of Consumption—Nystrom.

D. American Standards and Planes of Living—Elliott.

E. The Costs of Medical Care—Falk, Rorem, and Ring.

F. Other material to be obtained.

II. Experience of Local Agencies:

A. Family Relief Unit.

B. Veterans' Relief Unit.

C. Medical School Clinic.

D. Jewish Federated Agencies.

E. Catholic Charities.

4021 III. VARIOUS "LEVELS" CONSIDERED IN GENERAL STUDIES:

A. Bare subsistence.

B. Minimum for health and efficiency.

C. Minimum comfort—the decency level.

D. Comfort.

E. Moderately well-to-do.

F. Liberal.

IV. FACTORS TO BE CONSIDERED IN ARRIVING AT "COMFORT" LEVEL:

A. Should consider "family"—not the individual.

B. Family living expenses:

1. Food.
2. Shelter.
3. Clothing.
4. Miscellaneous expenses.
5. Development.
6. Health.
7. Savings

C. Size of family and ages.

D. Chronic illness and invalidism in family.

E. Assets.

F. Liabilities.

G. Previous illness.

H. Constant changes due to unemployment.

I. Ability of family to "manage" its affairs.

J. Unusual recent illness in family.

V. OREGON LAWS ON SUPPORT OF POOR

A. Responsibility of relatives to support.

1. Obstacles.

VI. THE "SOCIAL" VIEWPOINT

A. Paternalistic tendencies of Federal Government.

B. Accepted practices as to state responsibility to provide certain care.

1. Insane and feebleminded.
2. Tuberculosis.
3. Chronic diseases.
4. Contagious diseases.
5. Others.

C. Theories on Social Progress.

D. Practices of Social Service Agencies.

E. Demands of Labor.

F. Actions of public officers due to "demands".

4022 SECTION IV

STUDY OF "10-POINT" MEASURE OF A.M.A. APPLIED LOCALLY

I. THE 10-POINT MEASURE

A. All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

B. No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

C. Patients must have absolute freedom to choose a duly qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

D. The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician". This relation must be the fundamental and dominating feature of any system.

E. All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequcy and character of such institutions. Their value depends on their operation according to medical standards.

F. However the cost of medical service may be distributed, the immediate cost should be borne by the patient if able to pay at the time the service is rendered.

G. Medical service must have no connection with any cash benefits.

H. Any form of medical service should include within its scope all qualified physicians of the locality covered by its operation who wish to give service under the conditions established.

I. Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

J. There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

II. Under each of the above Headings Income Include an Analysis of Local Organizations, Showing:

A. Whether they conform to each point.

B. Conform in part.

C. Cannot meet requirements.

D. Number out of the ten in which they "acceptably" conform.

E. Indicate by what modifications they might conform on part of the principles.

4023

SECTION V

Reactions of those not Members of the Medical Profession

Reactions of those affected by or interested in Sickness Insurance who are not members of the medical profession, such as, patients, employers, public officials, social workers, etc.

SECTION VI

Summary

Material and findings to be summarized to aid committee in studies and conclusions.

SECTION VII

Conclusions and Recommendations By Special Committee

Plaintiff's Exhibit 212

4024

Report No. 3

OF THE OREGON STUDY OF MEDICAL CARE FOR LOW-INCOME GROUPS
Multnomah County Medical Society

STATISTICAL STUDY

of the

MULTNOMAH INDUSTRIAL HEALTH ASSOCIATION

March 18, 1935.

CONFIDENTIAL REPORT
Information for Members of Special Committee

Report No. 3

Copy No. 2

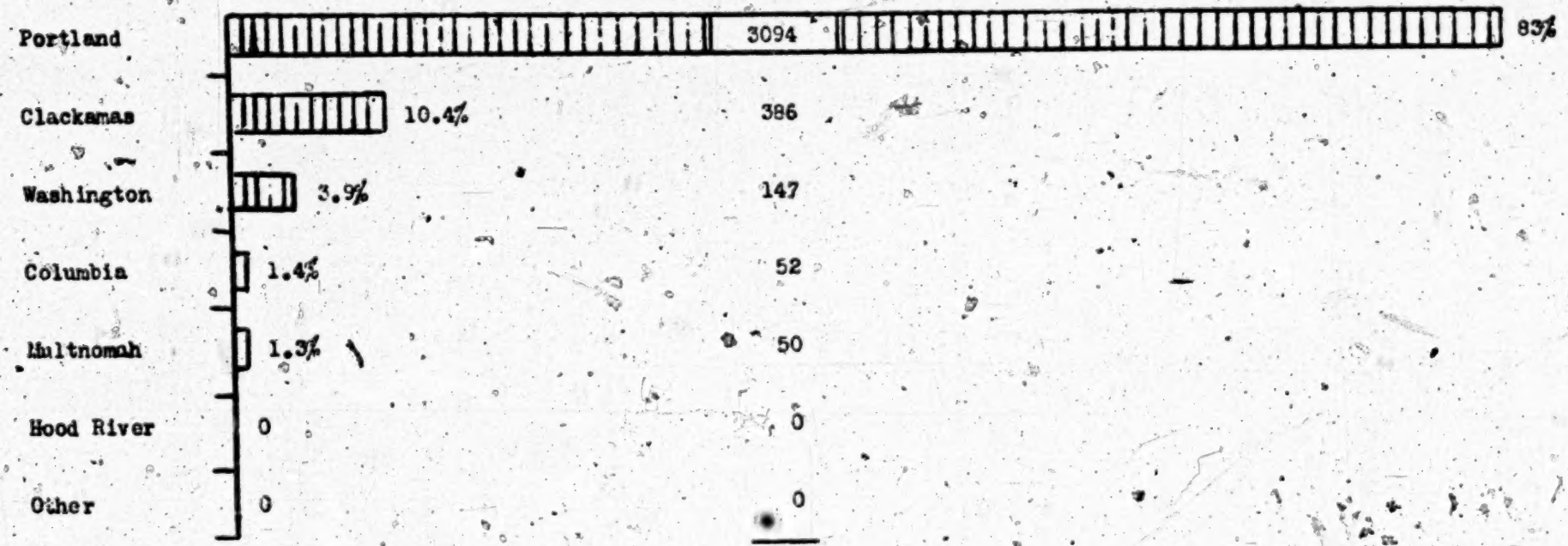
Dr. M. H. Jones

2602
4025

Diagram No. 3

TERRITORIAL COVERAGE

(Basis Subscribers)



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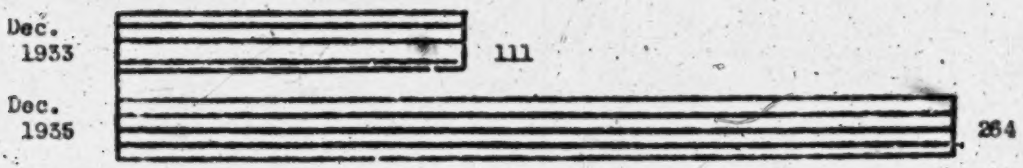
GROWTH OF ASSOCIATION
(Dec. 31, 1933 to Dec. 31, 1934)

SUBSCRIBERS

NUMBER OF CONTRACTS



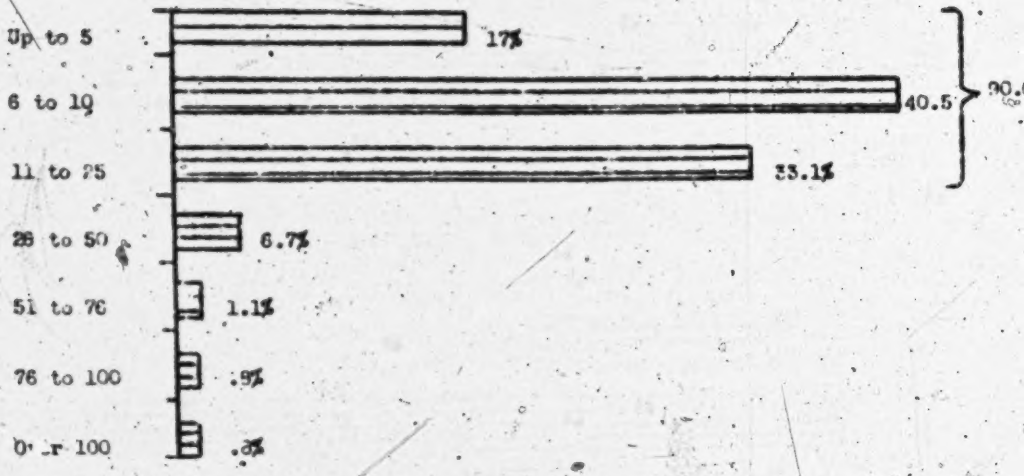
PHYSICIAN-MEMBERS

SURPLUS

Total Increase in Surplus 257%

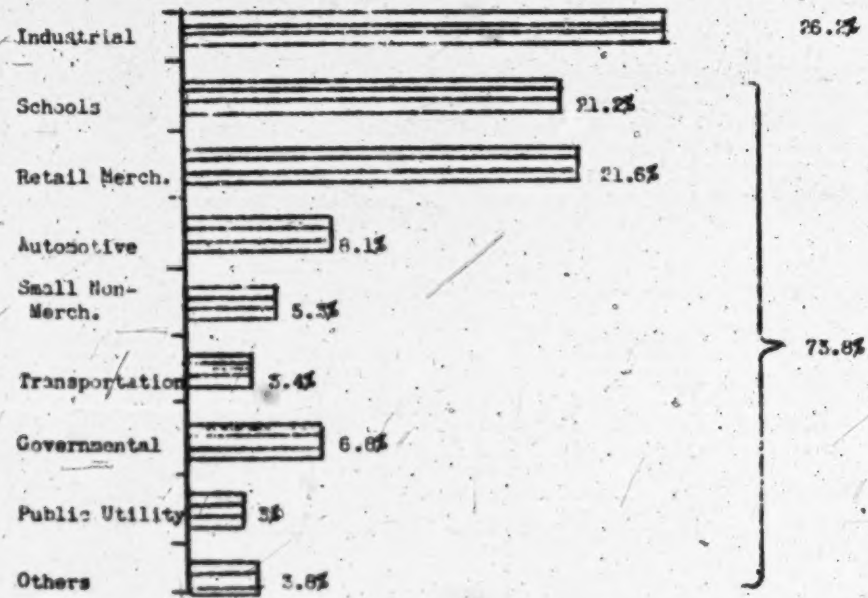
SIZE OF CONTRACTS

Diagram No.I



TYPE OF ORGANIZATIONS

Diagram No.2



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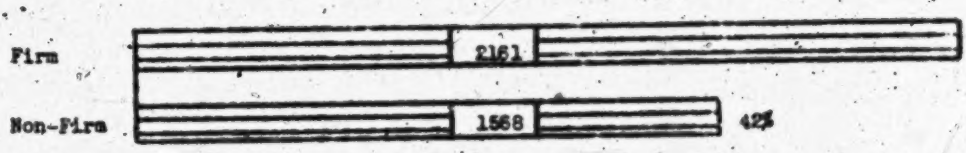
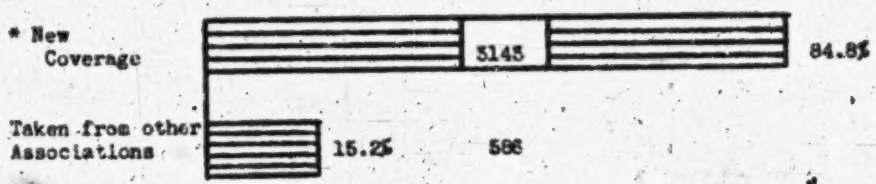
FIRM AND NON-FIRM SUBSCRIBERS



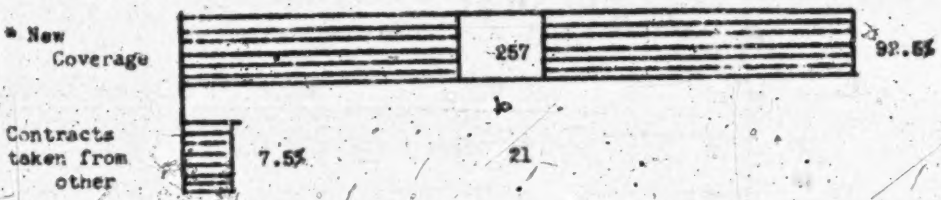
Non-Firm inculdes clubs, associations or individuals in firms.

SUBSCRIBERS TAKEN FROM OTHER ASSOCIATIONS



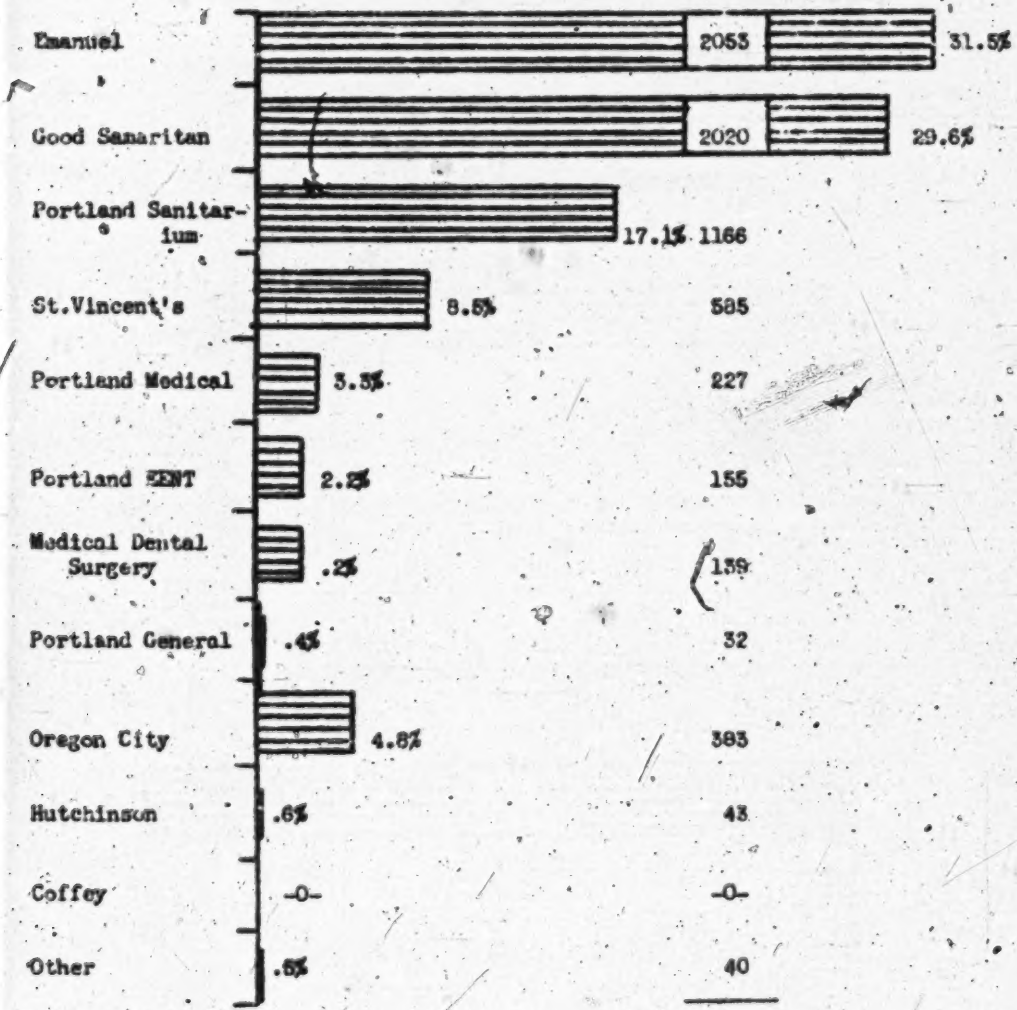
* Includes some school teachers who were under previous coverage but no data on available number.

CONTRACTS TAKEN FROM OTHER ASSOCIATIONS.

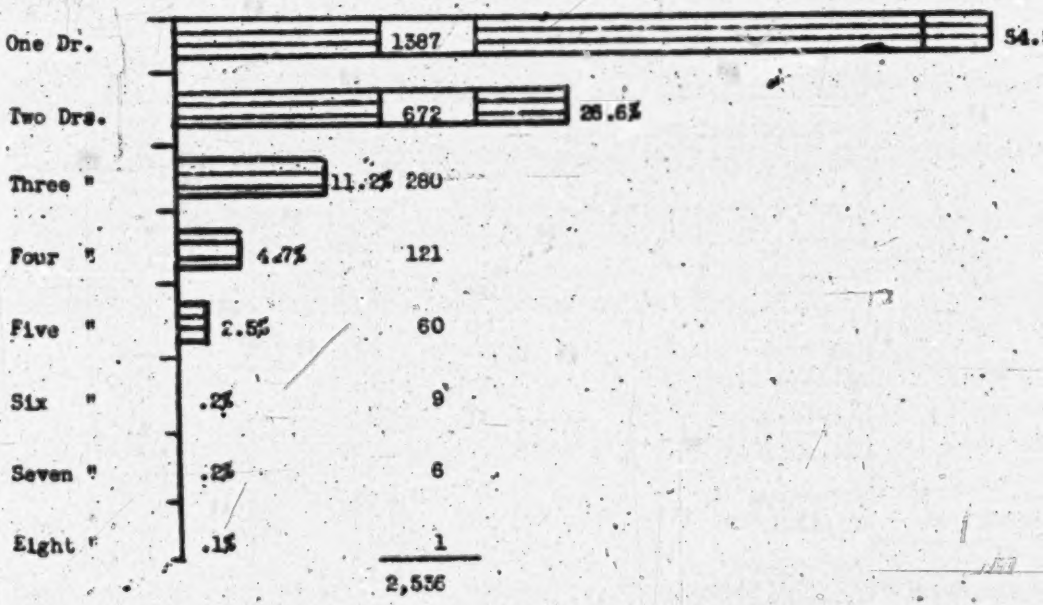


HOSPITAL PAYMENTS

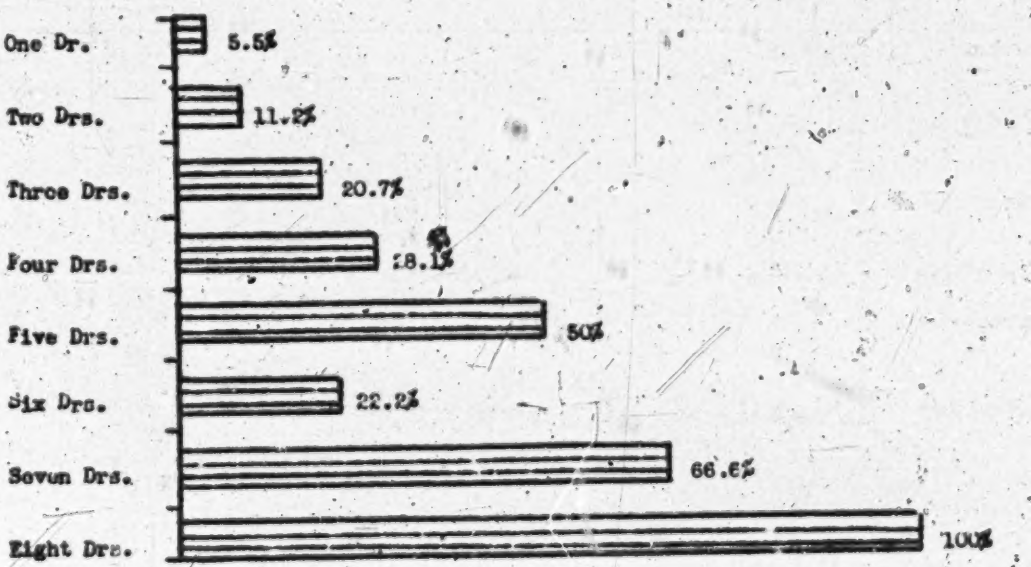
(Represents full costs.)



A STUDY OF NUMBER DOCTORS PER PATIENT

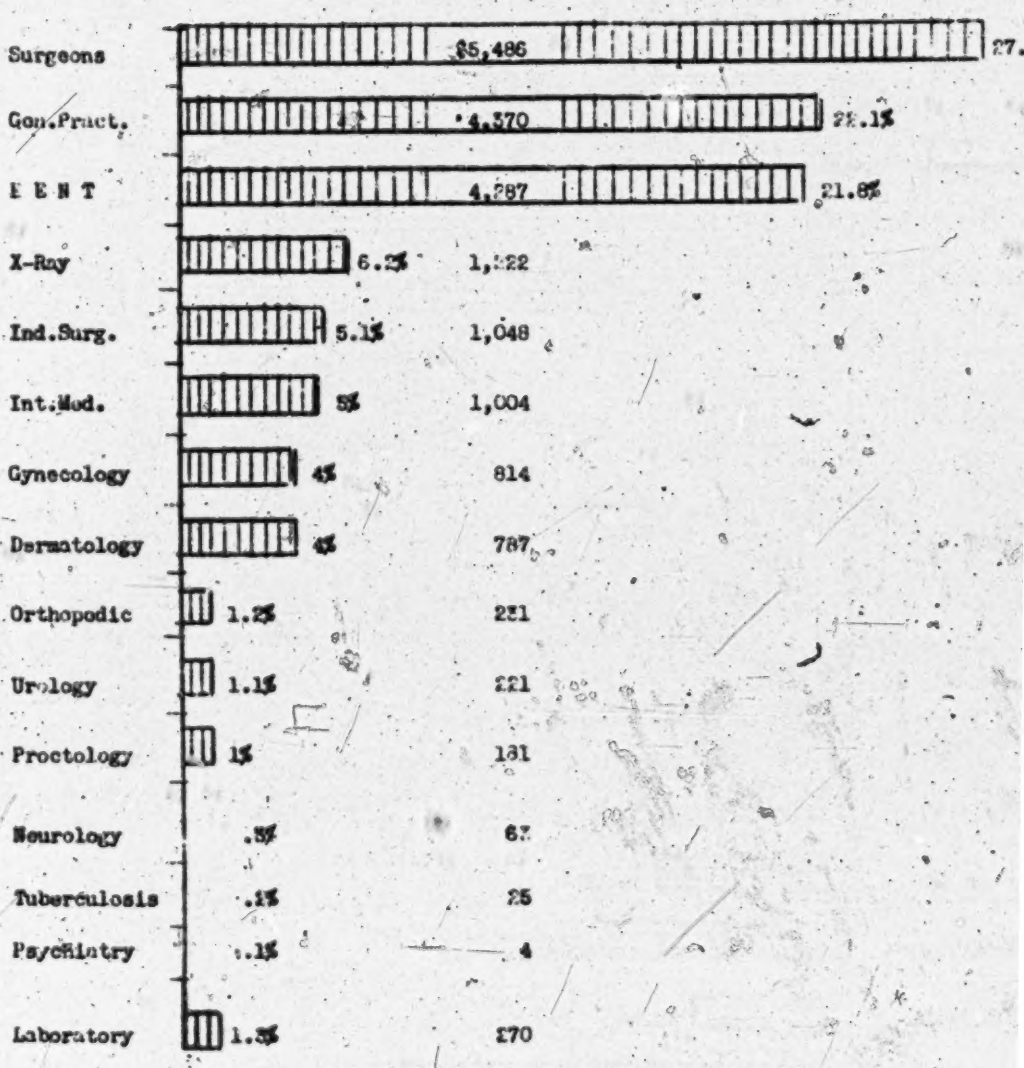


SCHOOL-TEACHER PERCENTAGE OF ABOVE PATIENTS



TOTAL PAYMENTS

PORTLAND PHYSICIAN MEMBERS



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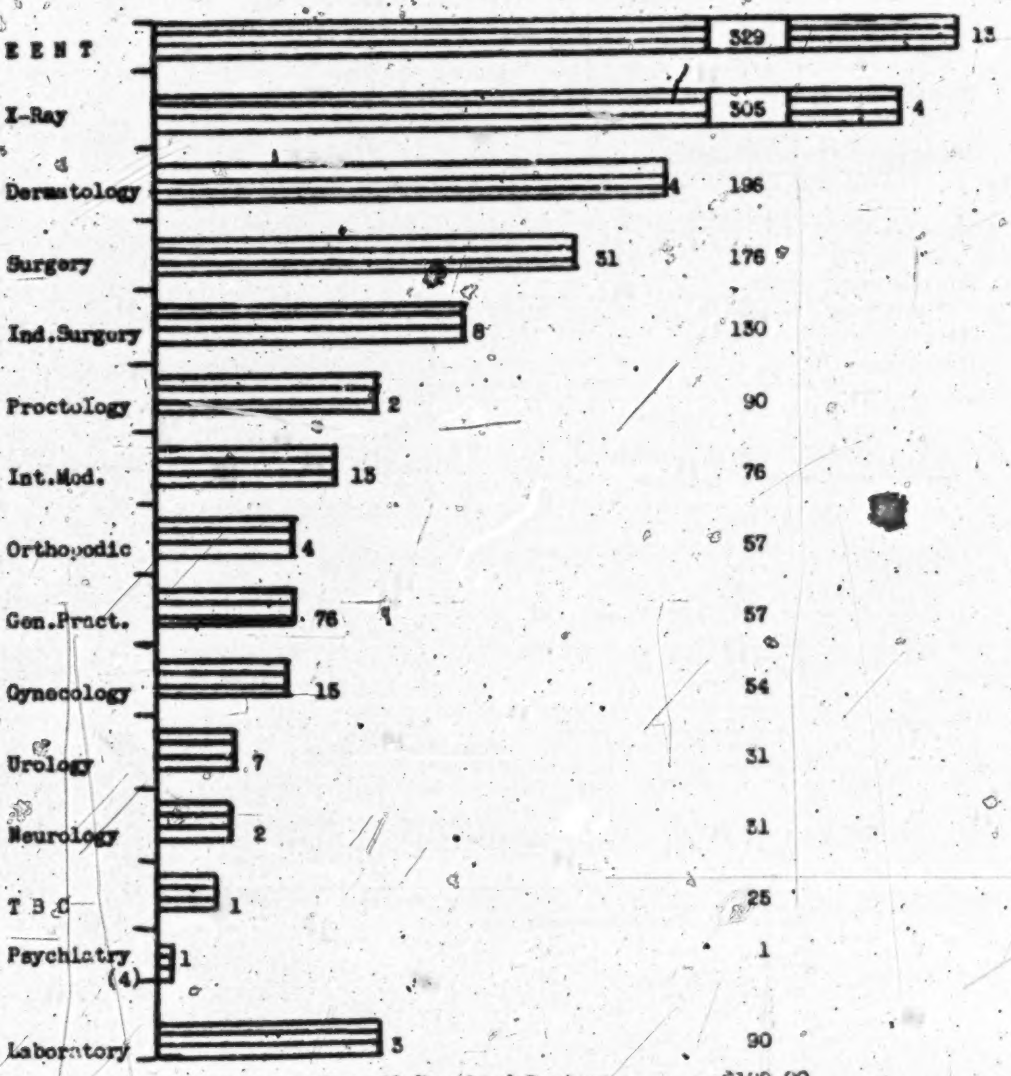
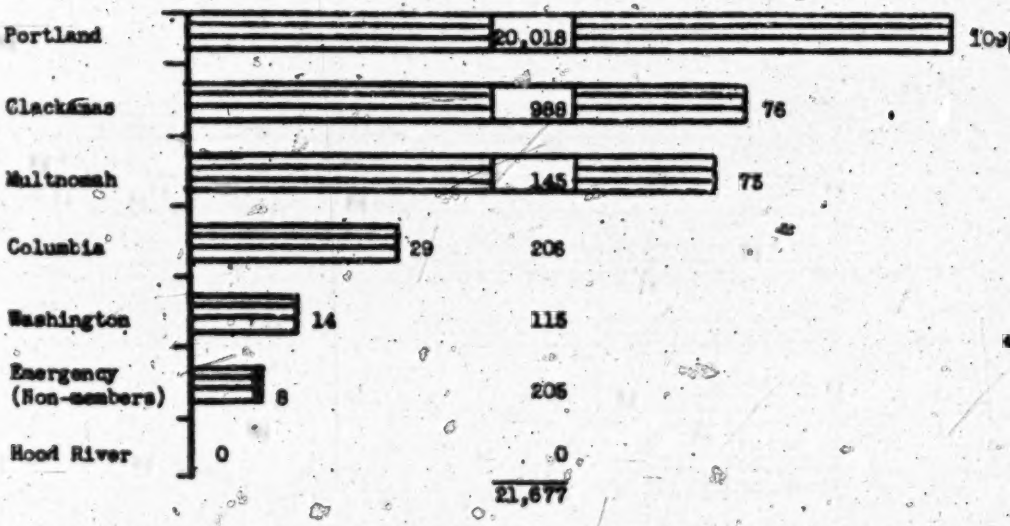
AVERAGE PAYMENTS PER PORTLAND DOCTOR

Classified by Specialties



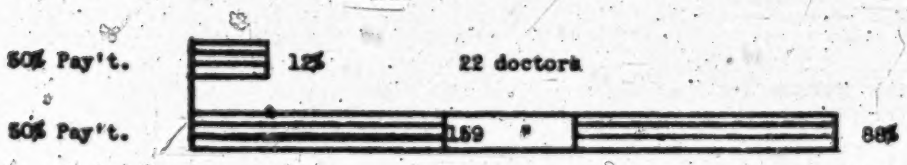
Average for all Portland Doctors $109.00
Total Portland Doctors 184

AVERAGE PAYMENTS TO ALL DOCTORS



Average payment per doctor to all physicians, including 25 non-members who rendered emergency service - - - - - - - - - - - - - - - - - - $88.00

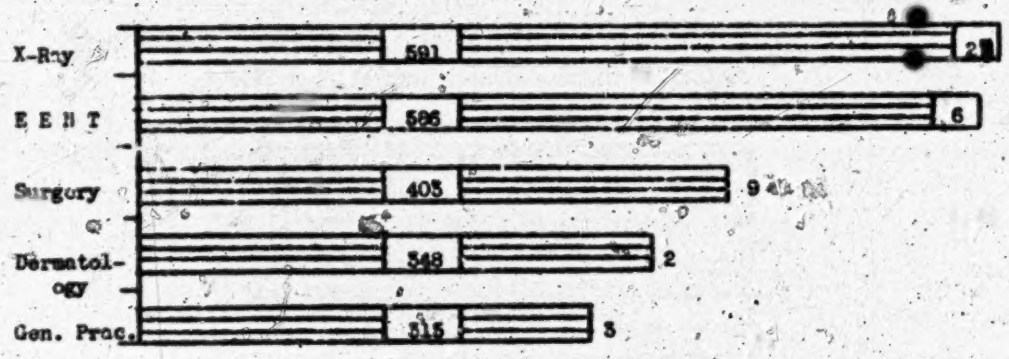
RECAPITULATION OF PAYMENTS TO PORTLAND DOCTORS



RECAPITULATION

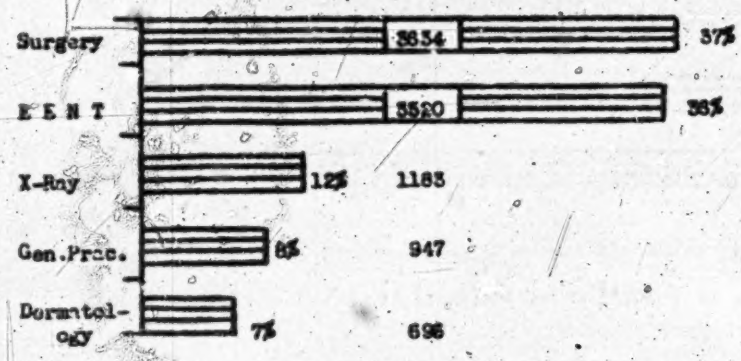
Special Study of First 22 Doctors Who Received 50% of Payments

AVERAGE PAYMENT PER DOCTOR



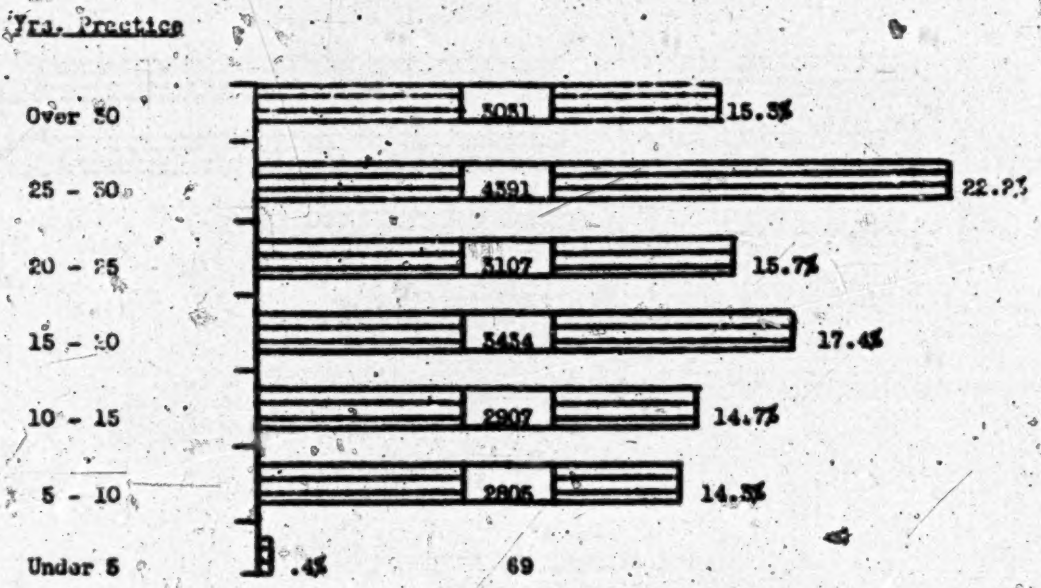
Average per doctor for first 22 (50%) - - - - - - - - $454.00

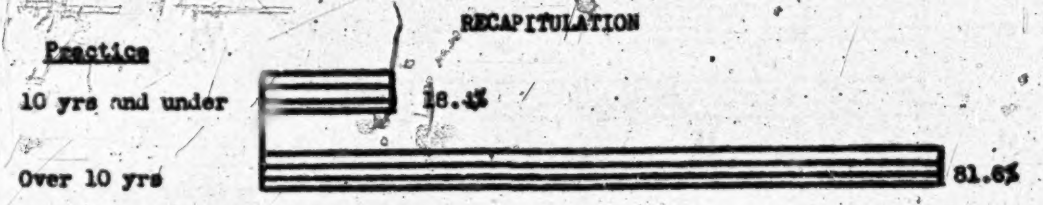
DOCTOR-PAYMENTS BY SPECIALTIES
(First 22 doctors)



DISTRIBUTION BY YEARS OF PRACTICE
Payments to Doctors 1934

This graph indicates distribution of practice by years out of medical School. Is this type of organization adapted to the younger physician starting practice?





Average age of Physicians on Panel . . . . . 47 years

Median age of Physicians on Panel . . . . . 47 years